

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR 72 HOURS. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 1 1 7 5 2
1. DECEASED NAME (TYPE OR PRINT) MILLIE F. ABERNATHY						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> 5-13-82		2b. HOUR M		
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9-17-1883	6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 5-13-82	7d. HOUR 9:58A		7e. HOUR M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3119 Chesterfield Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3119 Chesterfield Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Jasper Strickling				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Benton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-54-9799		17. INFORMANT ADDRESS Janice Abernathy (dghtr) same address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Margaret A. Koroll M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 5-14-82		
EXAMINER'S NAME (TYPE OR PRINT) Margaret A. Koroll, M.D.				ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/82		23c. NAME OF CEMETERY OR CREMATORY Oak Dale		23d. LOCATION CITY OR TOWN COUNTY STATE Spring Hope, N.C.				
24. FUNERAL DIRECTOR NAME ADDRESS Schumanek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE James S. [Signature]				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 7 5 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CALVIN H ADAMS				2a. DATE OF DEATH MONTH DAY YEAR 5 27 82 2b. HOUR 6:15 PM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 9 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian (Retired) MPer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Balto 13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 617 W Seminary Ave			
14. FATHER'S NAME FIRST MIDDLE LAST 030 ELIJAH Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Webb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT NAME ADDRESS Make Adams 617 W Seminary Ave Lutherville, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Osteoarthritis
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 23 Feb 19 81 , to 27 May 19 82 , that (I) (we) last saw the deceased alive on 27 May 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Gordon				DEGREE MD		22c. DATE SIGNED 27 May 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/1/82		23c. NAME OF CEMETERY OR CREMATORY Pleasant Rest		23d. LOCATION CITY OR TOWN COUNTY STATE Towson Balto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Chatman #14 1701 McCulloch St.				25a. DATE REC'D. BY REGISTRAR JUN 2 1982		25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11754	
1. DECEASED NAME (TYPE OR PRINT) Yvette Y. Adams						2a. DATE KNOWN OF DEATH 5 5 19 82		2b. HOUR M			
3. SEX female	4. RACE black	5. DATE OF BIRTH 8 30 65	6. AGE (IN YEARS) 16 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 5 5 19 82		7d. HOUR 1:30A			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2808 W. Garrison Avenue			
14. FATHER'S NAME Frank Adams				15. MOTHER'S MAIDEN NAME Marie Evans							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Marie Adams 2808 W. Garrison Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple injuries with complications IMMEDIATE CAUSE (a) 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 3AM 4/25 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by vehicle							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION 2000 Blk Gwynn Falls Pkwy, Balto City, MD							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE H. R. Guard		TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5/5/82					
EXAMINER'S NAME (TYPE OR PRINT) Dr. Hormez R. Guard		ADDRESS 111 Penn Street, Balto, MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/10/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.			23d. LOCATION Baltimore COUNTY MD STATE				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR MAY 7 1982		25b. REGISTRAR'S SIGNATURE Frances Jean Nathan		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

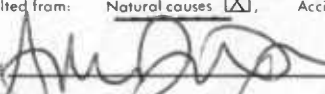

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 7 5 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) LUCILLE F. ADGER				2a. DATE OF DEATH MONTH DAY YEAR 05 26 82				2b. HOUR 5:30 AM	
3. SEX Fe		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 15 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shallotte, N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly		12b. KIND OF BUSINESS OR INDUSTRY Factory	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 842 Bridgeview			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN BALTO					
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Frank				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Bryant					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ellwood Frink 6806 Lenbean					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) ALVEOLAR CELL CARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. DIABETES mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/2/82 to 5/26/82 , that (I) (we) last saw the deceased alive on 5/25/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] M.D.				DEGREE M.D.				22c. DATE SIGNED 5/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HALIMA				22e. ADDRESS ST. AGNES HOSPITAL 900 CATON AVENUE BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL CITY BURIAL		23b. DATE 5-29-82		23c. NAME OF CEMETERY OR CREMATORY KING MEMPK.		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, Md.			
24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS				ADDRESS 1701 LAURENS		25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8211756	
1. DECEASED NAME (TYPE OR PRINT) ESTELLE ALI						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 21 YEAR 1982		2b. HOUR 10:35			
3. SEX female	4. RACE Negro	5. DATE OF BIRTH MONTH FEB DAY 12 YEAR 1890	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD MONTH 5 DAY 21 YEAR 1982		2d. HOUR 10:35			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3204 HAWKINS PT. ROAD			
14. FATHER'S NAME FIRST GENOA MIDDLE PITTS LAST				15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE FRANCES LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-28-6348D		17. INFORMANT ADDRESS RD. 21226 THELMA J. TAYLOR/3204 HAWKINS PT.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 5-22-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 05/25/82		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL				23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE			
24. FUNERAL DIRECTOR MARSHALL W JONES, JR.						25a. DATE REC'D. BY REGISTRAR MAY 25 1982 25b. REGISTRAR'S SIGNATURE 					

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1873

REV 82-1000
New England

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11757	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST Edward MIDDLE Floyd LAST Allen Jr			2a. DATE KNOWN OF DEATH			2b. HOUR		
3. SEX male			4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 4 13 82		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS YRS. 1 3		7c. DATE PRONOUNCED DEAD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 910 E. Biddle Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 910 E. Biddle St.		
14. FATHER'S NAME FIRST Edward MIDDLE F. LAST Allen Sr.			15. MOTHER'S MAIDEN NAME FIRST Ernestine MIDDLE Walker LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A		
17. INFORMANT Ernestine Walker			ADDRESS 910 E. Biddle St.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Sudden Infant Death Syndrome IMMEDIATE CAUSE (a) 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 5/16/82		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/19/82			23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H			ADDRESS 1101 E. North Ave.			25a. RECEIVED BY REGISTRAR MAY 19 1982			25b. REGISTRAR'S SIGNATURE		

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Handwritten text at the bottom left corner, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

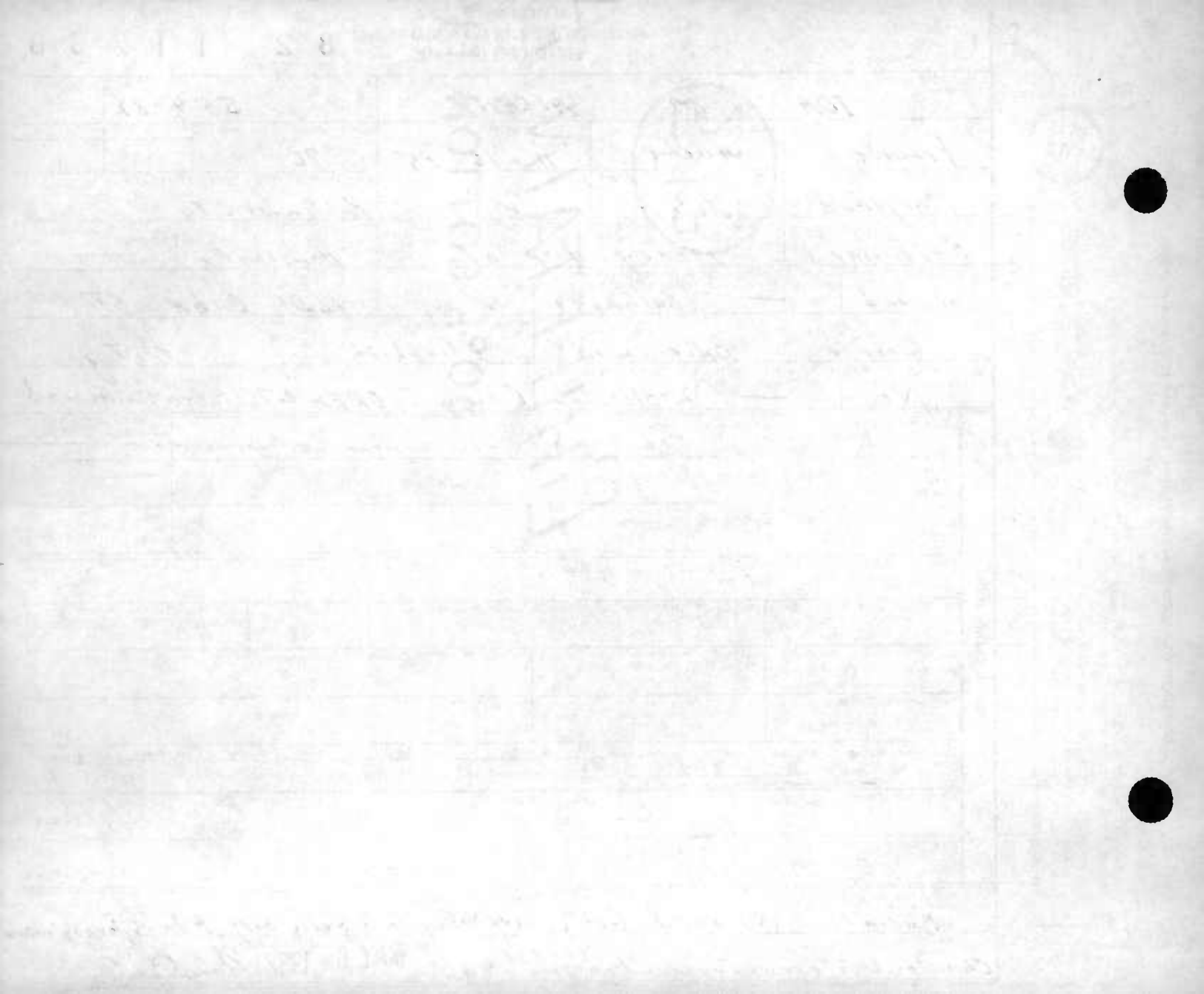
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 5 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA M. ALLEN			2a. DATE OF DEATH MONTH DAY YEAR 5-4-82			2b. HOUR 4³⁰ AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-10-05		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1641 Cuba St.	
14. FATHER'S NAME FIRST MIDDLE LAST Groose Brickerman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Stitz			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 219-18-8966			17. INFORMANT NAME ADDRESS Calvin E. OREM, 4751 Millers Station Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRANSITIONAL CELL CANCER OF THE BLADDER 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 5/2 , 19 82 , to 5/4 , 19 82 , that (I) (we) lost saw the deceased alive on 5/4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R MAGGIN			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R MAGGIN			22e. ADDRESS MERCY HOSPITAL, BALTIMORE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/7/82		23c. NAME OF CEMETERY OR CREMATORY Gettysburg National Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Gettysburg, Adams, Pennsylvania		
24. FUNERAL DIRECTOR NAME Charles L. Stevens Funeral Home, Inc.			ADDRESS 1501 E. FORT AVE.			25a. DATE REC'D. BY REGISTRAR MAY 6 1982		25b. REGISTRAR'S SIGNATURE Thane J. [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR Sidney M. Allen					8 2 1 1 7 5 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Sidney M. Allen					2a. DATE OF DEATH MONTH DAY YEAR 5 12 82			2b. HOUR 9:00 PM	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 27 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) File Driver		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE MD		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3969 Brooklyn Ave	
14. FATHER'S NAME FIRST MIDDLE LAST William Allen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Murray				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE YEAR OR DATES) WWI		17. INFORMANT Clara G. Allen (same as 13e)		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) M2 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dehydration, renal failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-2 19 82 , to 5-12 19 82 , that (I) (we) last saw the deceased alive on 5-2 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.A. Arena					DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5-12-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 3001 S. Hanover St.				
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 5/17/82		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME Balto., Md. 21225 Gonce F.H. 4001 Ritchie Hwy.					25a. DATE REC'D. BY REGISTRAR MAY 17 1982		25b. REGISTRAR'S SIGNATURE James J. Thayer		

— 2 —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 6 0 REG. NO.						
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) SUSAN ALTHOUSE							2a. DATE OF DEATH MONTH DAY YEAR 5 11 82			2b. HOUR 7:50am	
3 SEX F Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 3 39			6 AGE (IN YEARS LAST BIRTHDAY) 42 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH CITY MD.								
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOLY TRINITY MONASTERY			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2135 LORRAINE AVE 21207								
14. FATHER'S NAME FIRST MIDDLE LAST Robert Christian					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Moses											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 205-30-3511		17. INFORMANT CHART			ADDRESS SINAI HOSPITAL						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL CA- RESP. ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA- LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (this hospital) attended the deceased from 3-30-1982 to 5-10-1982 , that (I) (we) last saw the deceased alive on 5-10-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Sheila Ebenezer DEGREE MBBS ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHEILA EBENEZER						22e. ADDRESS SINAI HOSPITAL, BALTO. MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 14 May 82		23c. NAME OF CEMETERY OR CREMATORY Security Process			23d. LOCATION Catonsville, Balto., Md. STATE							
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.						25a. DATE REC'D. BY REGISTRAR MAY 12 1982			25b. REGISTRAR'S SIGNATURE James S. Kirkley							

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at 1507 BP.

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 6 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HENRY LEE AMES					2a. DATE OF DEATH MONTH DAY YEAR 5-22-82			2b. HOUR 8 10 AM			
3 SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5-26-93		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY, BALTO. MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Family			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. STATE MD		13b. COUNTY BALTIMORE		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 1507 N. FULTON ST.					
14. FATHER'S NAME FIRST MIDDLE LAST JESSE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUVENIA FINNEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-30-5030		17. INFORMANT Baltimore Maryland 21217 Mrs. Helen Bates 1507 N. Fulton Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS 5325 DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED DUODENAL ULCER DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD & CHF & COPD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 5 DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: ASCVD & CHF & COPD											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5-03 , 19 82 , to 5-22 , 19 82 , that (I) (we) last saw the deceased alive on 5-21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Oscar E. Fernandini MD						DEGREE MD		22c. DATE SIGNED 5-22-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSCAR E. FERNANDINI						22e. ADDRESS BON SECOURS HOSP. BALTO., MD. 21223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/27/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, County, Maryland				
24. FUNERAL DIRECTOR NAME BALTIMORE ADDRESS MARYLAND 21216 Herbert E. Nutter Funeral Home 3035 W. NORTH AVE.						25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE Thomas J. ...			

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2-25-83 2 10

HENRY LEE AMER

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2-25-83

BLACK

WHITE

1171 BNG

USA

VA

BALTIMORE BOYSCOUTS HOPE

1205 HUNTER

BALTIMORE

MD

AMER

AMER

WHITE

210-30-2000 Medical Records

210-30-2000

REPUTATION

REPUTATION

REPUTATION

2-25-83

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2-25-83

REPUTATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE																	
1- FOR STATE REGISTRAR					8 2 1 1 7 6 2												
CERTIFICATE OF DEATH					REG. NO.												
1. DECEASED NAME (TYPE OR PRINT) MARYANN AMOS					2a. DATE OF DEATH MONTH DAY YEAR MAY 10, 1982					2b. HOUR 07:17AM							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 1, 1910			6. AGE (IN YEARS LAST BIRTHDAY) 72			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7. BIRTHPLACE (STATE OR FOREIGN) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.										
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE Virginia					13b. COUNTY Russell		13c. CITY OR TOWN Cleveland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS PO Box 172	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace Hocks					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettle Addison												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 223 72 6820			17. INFORMANT ADDRESS Thomas J. Amos, Sr same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diffuse Atherosclerosis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 3 days and 6 days. Several years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Gangrene of (L) 5th toe																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 4/26 , 19 82 , to 5/10 , 19 82 , that (I) (we) last saw the deceased alive on 5/10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Anthony Elias				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/10/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY ELIAS				22e. ADDRESS JOHNS HOPKINS HOSPITAL													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 13, 1982		23c. NAME OF CEMETERY OR CREMATORY Amos Family Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cleveland, Virginia							
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Maryland										25a. DATE REC'D. BY REGISTRAR MAY 17 1982				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 6 3

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Edgar LEE ANDERSON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-25-82</i>		2b. HOUR <i>6³⁰ A.M.</i>								
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 27 1929</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>53</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.							
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ST AGNES HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Custodian</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ho. Co. Schl.</i>					
13a. STATE <i>Maryland</i>						13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Catonsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2315 Westchester Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edgar R Anderson</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Thompson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>219 28 7295</i>		17. INFORMANT ADDRESS <i>Walter R. Anderson 2315 Westchester Ave. Catonsville</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastatic small ca of lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>5-24-</i> 19 <i>82</i> , to <i>5-25</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>5-25</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Kareem Said</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>5/25/82</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kareem Said</i>						22e. ADDRESS <i>900 CATON AVE BALTIMORE MD 21229</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/27/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Crest Lawn Mem. Gardens</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Marriottsville, Howard, Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>SLACK Funeral Home, Ellicott City, Maryland 21043</i>					
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

ST. AGNES HOSPITAL

300 CATCH AVE BALTIMORE MD 21222

STATE OF MARYLAND, DISTRICT OF COLUMBIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 1 7 6 4	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HAROLD Bernard ANDERSON						2a. DATE OF DEATH MONTH DAY YEAR 05 25 82		2b. HOUR 2:00 AM			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 03 12 24		6. AGE (IN YEARS LAST BIRTHDAY) 58		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEB		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VICE-PRESIDENT		12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md		13b. COUNTY BALTO		13c. CITY OR TOWN PHOENIX		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1 COLLINGWOOD GARTH			
14. FATHER'S NAME FIRST MIDDLE LAST HAROLD --- ANDERSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENEVA M. ROBERSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 508-18-4731		17. INFORMANT ADDRESS Phyllis A. Anderson, 1 Collingwood Garth							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mediastinal bleeding 5192 DUE TO, OR AS A CONSEQUENCE OF (b) non-union sternum closure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) mediastinitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) renal failure, ischemic encephalopathy, respiratory distress											
19a. DATE OF OPERATION 4-27-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED coronary artery disease				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-25 , 19 82 , to 5-25 , 19 82 , that (I) (we) last saw the deceased alive on 5-25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Sergio TAVARES, M.D.						DEGREE MD		22c. DATE SIGNED 5-25-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SERGIO TAVARES, M.D.						22e. ADDRESS University Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/27/1982		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Maryland					
24. FUNERAL DIRECTOR NAME Lemmon-Mitchell-Wiedefeld Inc.						ADDRESS 10 W. Padonia		25a. DATE REC'D. BY REGISTRAR JUN 1 1982			
						25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11765	
1. DECEASED NAME (TYPE OR PRINT) Joseph Edward Anderson						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 19 YEAR 1982		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 4 YEAR 45		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 5 DAY 19 YEAR 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4111 Southern Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Security			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4111 Southern Avenue-21206			
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Anderson Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia E. Wendt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 219-44-7354		17. INFORMANT ADDRESS Sophia E. Durdan - 4111 Southern Ave. - 212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Multiple gunshot wounds Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:10xx 5 19 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4111 Southern Ave. Balto. Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE H.R. Guard				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5/19/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5-21-82		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR John C. Miller Inc.						ADDRESS 6415 Belair Rd. - 21206		25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Nathan	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

Item 23c #G567 5/14/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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FOR
1 - STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST	MIDDLE	MONTH	DAY	YEAR	
Pearl Anderson		May 10, 1982		2:08a M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	Black	MONTH	DAY	YEAR	
		7	12	12	69
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	U.S.A.			Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Maryland General Hospital				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
MD			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		13e. STREET ADDRESS	
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
unkn		unkn		1730 St. Paul Street	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-14-4903		Mattie Jones 2418 Barton Ave. Richmond	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 1509 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hyperosmolarity/Acidosis (b) } (c) Carcinoma of the Esophagus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Adult Onset, Diabetes Mellitus.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
May 5, 1982		Carcinoma of the Esophagus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from April 27, 1982, to May 10, 1982, that (X) (we) last saw the deceased alive on May 10, 1982, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Ronnie McMurry, M.D.		C/O Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/14/82		Mt. Auburn Cem.	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Balto.				MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H, Inc. 1101 E. North Ave.		MAY 11 1982		James Van Natten	

100-100000-100000

May 10, 1985

Washington, D.C.

Washington General Hospital

Washington, D.C.

Washington, D.C.

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May 10, 1985

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Washington, D.C.

May 10, 1985

Washington, D.C.

Washington General Hospital

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 6 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Roosevelt Anderson					2a. DATE OF DEATH MONTH DAY YEAR May 4, 1982			2b. HOUR M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 26 13		6. AGE (IN YEARS (LAST BIRTHDAY)) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2829 Winchester St.			
14. FATHER'S NAME FIRST MIDDLE LAST Clyde Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vallie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 259-10-7896		17. INFORMANT ADDRESS Christine Wilson 1802 Mosher St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) No 2nd Cardiac Arrest 4275 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis & Aortic Pulmonary DUE TO, OR AS A CONSEQUENCE OF (c) Arrest.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1973 , 19 14 , to 1982 , that (I) (we) lost saw the deceased alive on March , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert A. Spaulding						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/4/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Spaulding						22e. ADDRESS 1540 W. Belth. Ave. 71223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/8/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 5 1982		25b. REGISTRAR James J. Nathan	

1871
Jan 1st
to
Jan 31st
1872

Amount paid
to
the
treasurer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 1 1 7 6 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT ALLEN ANDREWS					2a. DATE OF DEATH MONTH DAY YEAR 5 23 82				
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR SEPT 21 1925		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7b. HOUR 7:35P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US OF A		8. MARRIED <input checked="" type="checkbox"/> OVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V. A. HOSPITAL 3900 LOCH RAVEN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3315 BURLEITH AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES ANDREWS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES BARBEE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS MRS. MERITA D. ANDREWS 3315 BURLEITH AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE VAMC, BALTIMORE, MARYLAND 21218					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> 19 <u>82</u> , to <u>5-23</u> 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>5-23</u> 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE <i>Thomas B. Haywood mo</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>5/24/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas B. Haywood mo				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/28/82		23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN (BALTO.) MD.			
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN				ADDRESS 4517 PARK HEIGHTS AVENUE		25a. DATE REC'D. BY REGISTRAR MAY 28 1982			
				25b. REGISTRAR'S SIGNATURE <i>Thom J. North</i>					

BURIAL 5/28/32 ST. THOMAS CEMETERY BALDWIN (BALLO) MD.

LEWIS T. GYNN 4517 PARK HEIGHTS AVENUE

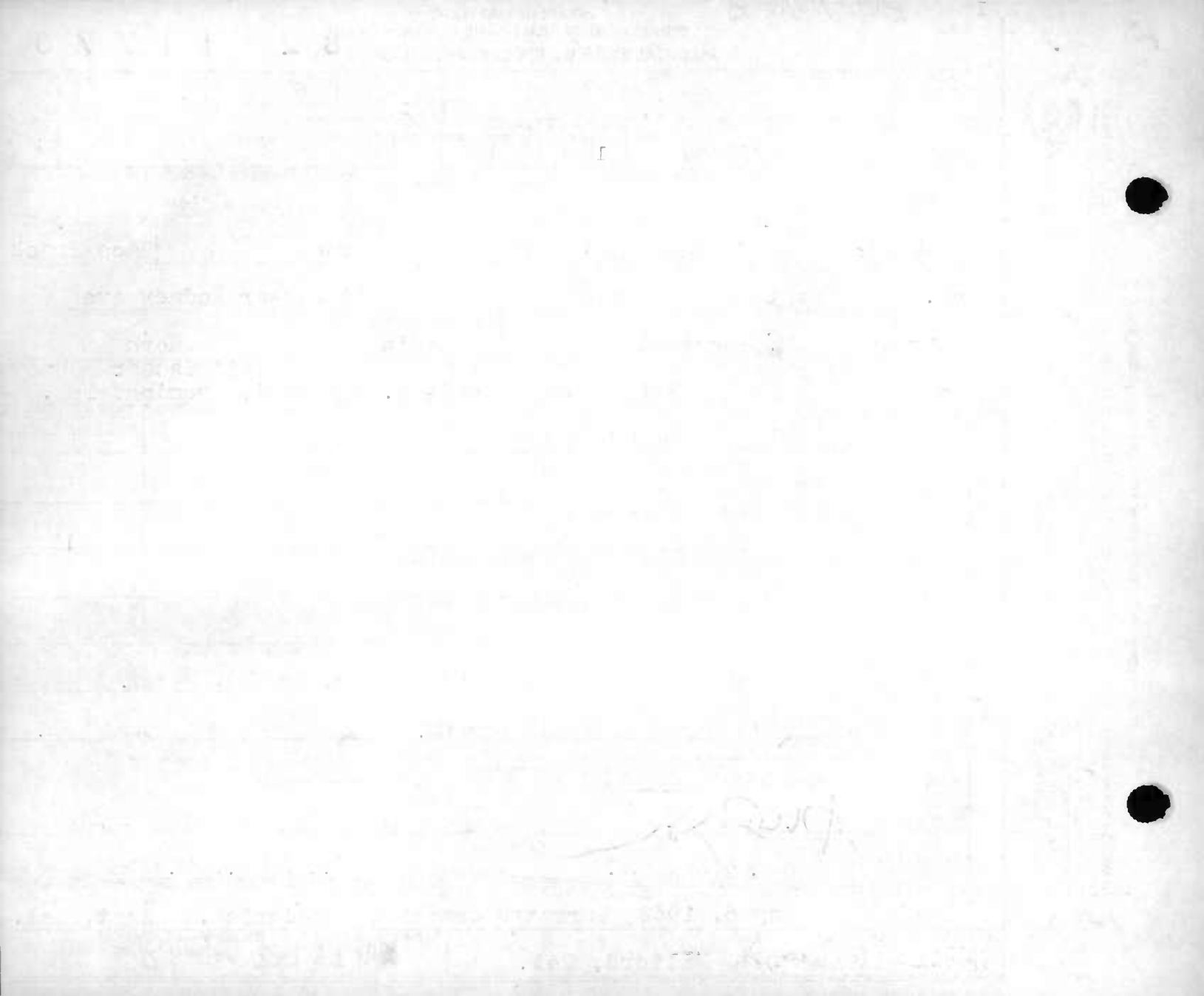
YES WM 11 304 26 0337 MRS. MERITA D. ANDREWS 3315 BUNNETH AVE.
CHARLES ANDREWS
FRANCIS
BARBER
MARYLAND BALTIMORE X 3315 BUNNETH AVE.
BALTIMORE V. A. HOSPITAL 3900 LOCH RAVEN UNEMPLOYED
VIRGINIA US OF A
MEMO SEPT 21 1932 26

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11770
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM C. ANGSTADT						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 2 19 82		2b. HOUR 6:35		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2/20/64	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 18	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 2 19 82		2d. HOUR a M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (DOA)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Groom		12b. KIND OF BUSINESS OR INDUSTRY Race Track		
13a. STATE Del.						13b. COUNTY Kent		13c. CITY OR TOWN Wyoming		
14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Angstadt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Horn		16. SOCIAL SECURITY NO. 221 40 4407						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 221 40 4407		17. INFORMANT ADDRESS Sadie H. Angstadt, Wyoming, Del.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 4:50xx 5-2- 19 82			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Driver in auto/fixed object impact.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TB PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION CITY OR TOWN COUNTY STATE Gorman Rd. Howard Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Ann M. Dixon, M.D.			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 5-3-82				
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 6, 1982		23c. NAME OF CEMETERY OR CREMATORY Barratts Chapel			23d. LOCATION CITY OR TOWN COUNTY STATE Frederica, Kent, Del.			
24. FUNERAL DIRECTOR NAME ADDRESS William A. Beatty Jr. Milford, Del.						25a. DATE REC'D. BY REGISTRAR MAY 12 1982		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 7 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ELMER E ANTLITZ					2a. DATE OF DEATH MONTH DAY YEAR 5/26/82			2b. HOUR 10:29 AM			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11/01/1914		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee		12b. KIND OF BUSINESS OR INDUSTRY Defense Dept.			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1311 Webster St. Balto. Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Antlitz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Croll						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-12-2540A		17. INFORMANT ADDRESS Mrs. Evelyn Antlitz, Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ca bladder DUE TO, OR AS A CONSEQUENCE OF (c) 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5/25 , 19 82 , to 5/26/ , 19 82 , that (I) (we) lost saw the deceased alive on 5/26/ , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ivaturi			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IVATURI			22e. ADDRESS Good Samaritan Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A.Co. Maryland			
24. FUNERAL DIRECTOR NAME M. Cully F.H.			120 th E. Fort Ave. Balto.			25a. DATE REC'D. BY REGISTRAR MAY 27 1982			25b. REGISTRAR'S SIGNATURE Charles Van Norder		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Jesse			MIDDLE M.			LAST Appy			2a. DATE KNOWN OF DEATH ESTIMATED			<input checked="" type="checkbox"/> MONTH 5			DAY 6			YEAR 19 82			2b. HOUR M 2:39 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/11/26		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 6 19 82			2d. HOUR P M										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.													
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Filler				12b. KIND OF BUSINESS OR INDUSTRY Oxygen									
13a. STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 306 S. Augusta Avenue											
14. FATHER'S NAME FIRST MIDDLE LAST Jesse M. Appy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Glanhart																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 214-22-5395				17. INFORMANT ADDRESS Mrs. Helen Appy 306 S. Augusta Avenue																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief Medical Examiner												DATE SIGNED 5/7/82									
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 5/10/82				23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland													
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home				ADDRESS 1328 Sulphur Spring Rd.				25a. DATE REC'D. BY REGISTRAR MAY 7 1982				25b. REGISTRAR'S SIGNATURE Frances Jan Nathan													

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100% CUMULATIVE INDEX

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 7 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anneliese D. Ardamica		2a. DATE OF DEATH MONTH DAY YEAR May 1, 1982		2b. HOUR M 	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 5 1914		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS HOURS MIN. 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 717 Woodbourne Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Major - German Air Force		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY 	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Milns		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothea Baesler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-60-9610		17. INFORMANT ADDRESS Franz Ardamica 717 Woodbourne Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1974					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 					
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 	
22a. I certify that (I) (the hospital) attended the deceased from 5-1 19 80 to 5-1 19 82 , that (I) (we) last saw the deceased alive on 3-11 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE David Goldscher MD		DEGREE 		22c. DATE SIGNED 5-3-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Goldscher		22e. ADDRESS Good Samaritan Hospital Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 5, 1982		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Baltimore, Maryland			
25a. DATE REC'D. BY REGISTRAR MAY 5 1982		25b. REGISTRAR'S SIGNATURE Francis J. Van Winkle			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George W Argenbright		2b. DATE OF DEATH MONTH DAY YEAR 5 9 82		2c. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 21, 1922	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS MONTHS DAYS HOURS MIN	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5900 Willet Avenue		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. STATE Maryland		13a. COUNTY Baltimore		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ? Argenbright		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mrs Lucy H Argenbright			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT ADDRESS Mrs Lucy H Argenbright 4219 Garland Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ASCVD</u> (c) <u>HCVD</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 22</u> 19 <u>76</u> to <u>MAY 09</u> 19 <u>82</u> , that (I) (we) lost the deceased alive on <u>APRIL 13</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <u>Teodulo Paglinauan</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 5-10-82	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Teodulo Paglinauan		22e. ADDRESS 7811 Wise Avenue Dundalk, MD. 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/13/82		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 11 1982	
25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 5 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roy R ARMETTA				2a. DATE OF DEATH MONTH DAY YEAR 5 13 82			2b. HOUR 5:15 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 11 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed			12b. KIND OF BUSINESS OR INDUSTRY Shoemaker		
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 317 Kingston Circle			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Armetta				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stefanina Muffoletto							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I				16b. SOCIAL SECURITY NO. 212-28-6799A		17. INFORMANT ADDRESS Miss Helen Armetta 317 Kingston Circle, Sykesville, MD 21784					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION 4/7/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF PANCREAS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 82 , to 5/13 , 19 82 , that (I) (we) lost saw the deceased alive on 5/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.											
22b. SIGNATURE [Signature]		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/13/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ACAN TEL		22e. ADDRESS SINAI HOSP.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/17/82		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Baltimore MD					
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Rd., Randallstown, MD 21133						25. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE MAY 17 1982 [Signature]					

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UNITED STATES
DEPARTMENT OF THE INTERIOR

TO THE SECRETARY OF THE INTERIOR
FROM THE COMMISSIONER OF THE GENERAL LAND OFFICE
SUBJECT: [Illegible]

WHEREAS [Illegible]
AND WHEREAS [Illegible]
IT IS THE POLICY OF THE UNITED STATES
TO [Illegible]

AND WHEREAS [Illegible]
IT IS THE POLICY OF THE UNITED STATES
TO [Illegible]

AND WHEREAS [Illegible]
IT IS THE POLICY OF THE UNITED STATES
TO [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 2 1 1 7 7 6 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) MACKIE R ARMSTRONG					2a. DATE OF DEATH MONTH DAY YEAR 5 28 82					2b. HOUR 4 25 A M
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 07 29 20		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE MARYLAND		13b. COUNTY CITY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 288 S SPRING COURT		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE HARGROVE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROBERTA TANN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 212-32-9013		17. INFORMANT ADDRESS John Armstrong 444 E. Sonoma Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 2500 DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/23, 19 82, to 5/28, 19 82, that (I) (we) lost saw the deceased alive on 5/28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Rebecca L Tomlinack MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5/28/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rebecca L Tomlinack					22e. ADDRESS University Maryland Hospital					
23a. BURIAL, CREMATION, REMOVAL (IF)			23b. DATE 6-2-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Anne Arundel G. Md.			
24. FUNERAL DIRECTOR NAME William J. Spier					ADDRESS 1639 N. Broadway		25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]	

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March 27 - 1882
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 23rd inst. in relation to the above matter.
I am sorry to hear that you are unable to attend to the matter at present, but I will endeavor to do so as soon as possible.
Very respectfully,
J. H. [Name]

Enclosed find a copy of the report of the [Name] for the year 1881.
I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

30% NOTION FREE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not delay in returning the certificate to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 7 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret R. Arnold			2a. DATE OF DEATH MONTH DAY YEAR 5 15 82			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 1 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House In The Pines-Belvedere				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.					13b. COUNTY Balto.		13c. STREET ADDRESS 4229 Euclid Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Franklin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cenith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT c/o 203 Rollingfield Rd. #21228 Mr. Hunter F. Arnold					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) M.I. 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): D.M.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 09/10 , 19 76 , to _____, 19 _____, that (I) (we) last saw the deceased alive on 5/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. LEBSON				22e. ADDRESS 3640 FORDS LANE 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-18-82		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS G.T. Schwab, P.A. 3512 Frederick Ave. 21229				25a. DATE REC'D. BY REGISTRAR MAY 21 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

• 3922

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 7 7 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard Roch Arostegui				2a. DATE OF DEATH MONTH DAY YEAR May 9, 1982				2b. HOUR 11:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 20, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nicaragua		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plastic Lam- inator		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Maryland		13b. CITY OR TOWN A.A.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 401 Central Avenue S.W.			
14. FATHER'S NAME FIRST MIDDLE LAST Hernon Arostegui				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Buford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT (Wife) Mrs. Dolores H. Arostegui		ADDRESS same as # 13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Upper GI bleed									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-13, 1982, to 5-9, 1982, that (I) (we) last saw the deceased alive on 5-9, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. L. Kirkwood M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. L. Kirkwood M.D.				22e. ADDRESS Deaton Medical Center Balt, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 13 May 82		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION Glen Burnie, A.A., MD.			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home MD.				25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

WVA 13 505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 7 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CORA L ARTHUR			2a. DATE OF DEATH MONTH DAY YEAR 5 30 82		2b. HOUR 2:20 AM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 11 12 21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST FRANKLIN ARTHUR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LIZZIE ARTHUR		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-22-3190		17. INFORMANT ADDRESS Paulette Flowers 4217 Towanda Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-29 , 19 82 , to 5-30 , 19 82 that (I) (we) lost saw the deceased alive on 5-29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M J Butler DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5-30-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M J BUTLER				22e. ADDRESS 4, Md. Hosp	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/3/82		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.	
23d. LOCATION CITY OR TOWN Balto.		COUNTY BALTO.		STATE MD	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H, Inc. 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUN 3 1982 25b. REGISTRAR'S SIGNATURE Juanita	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 7 8 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARVIN C ASHBURN, Sr.				2a. DATE OF DEATH MONTH DAY YEAR HOUR 5 20 82 1145 PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 12 02		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL MASON F. LORD BLDG.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY - 13c. CITY OR TOWN BALTO 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3528 Elmora Ave			
14. FATHER'S NAME Richard Ashburn LAST				15. MOTHER'S MAIDEN NAME Anna (nee Jackson) FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-09-5638		16c. HOME ADDRESS 3528 Elmora Avenue, Balto., Md. 21213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular arrhythmias (c) - DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-6-81 , 19____, to 5-20-82 , 19____, that (I) (we) last saw the deceased alive on 5-20-82 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE William A. Dombrowski MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-21-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM DOMBROWSKI				22e. ADDRESS BALTO CITY HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/22/82		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME Seidmanek Funeral Home, Inc. ADDRESS 3331 Brehms Lane, Balto., Md. 21213				25a. DATE REC'D. BY REGISTRAR MAY 21 1982 25b. REGISTRAR'S SIGNATURE James J. [Signature]			

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Pauline Asti												2a. DATE KNOWN OF DEATH MONTH 5 DAY 10 YEAR 1982	2b. HOUR M 10 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 6 DAY 28 YEAR 1964	6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD MONTH 5 DAY 10 YEAR 1982	2d. HOUR M 10 AM		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9 Hillwood Rd					
14. FATHER'S NAME FIRST Francis MIDDLE J. LAST Asti				15. MOTHER'S MAIDEN NAME FIRST Doris MIDDLE B. LAST Asti									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-74-7513		17. INFORMANT Francis Asti		ADDRESS 9 Hillwood Rd. Elkton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and Cerebral Edema DUE TO, OR AS A CONSEQUENCE OF (b) Drowning DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:05 PM 5 9 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) passenger in auto that was submerged					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) creek				21f. LOCATION STREET Old Field Point Rd., CITY OR TOWN Elkton, COUNTY Cecil STATE Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia L. Dolan				M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 5-11-82	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 5-12-82		23c. NAME OF CEMETERY OR CREMATORY Cratin and Ferris				23d. LOCATION CITY OR TOWN West Chester COUNTY Pa. STATE Pa.			
24. FUNERAL DIRECTOR NAME Gee Funeral Home ADDRESS 259 E. Main St. Elkton, Md.				25a. DATE REC'D. BY REGISTRAR MAY 13 1982				25b. REGISTRAR'S SIGNATURE Francis J. N. N. N.					

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150015-1-02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 8 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Satirios M. Astifidis						2a. DATE OF DEATH MONTH DAY YEAR 5 8 82				2b. HOUR 7 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 1 98		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Contractor		12b. KIND OF BUSINESS OR INDUSTRY Constr.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE CITY OR TOWN Md. Baltimore Baltimore						13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 1337 Middleford Road					
14. FATHER'S NAME FIRST MIDDLE LAST Michael Astifidis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-22-3112		17. INFORMANT ADDRESS Mary Karebelas, 6208 Chesworth Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE 5860 DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 74 to 19 82, that (I) (we) last saw the deceased alive on 5/18/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE E. P. Williamson II M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. Williamson II						22e. ADDRESS 5550 BARTON NAT'L PK 21228							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-11-82		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.					
24. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR MAY 11 1982		25b. REGISTRAR'S SIGNATURE Thomas O. Matthews					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 1 7 8 3			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN M. BAKER						2a. DATE OF DEATH MONTH DAY YEAR 5 6 82				2b. HOUR 5:30 A.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 18 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) SHEET METAL WORK		12b. KIND OF BUSINESS OR INDUSTRY DIXIE MFG. CO.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTO. HGLDS.						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ER 4204 BALTIMORE ST., 21227					
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BAKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES KLUF									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-01-1956		17. INFORMANT ADDRESS HILDA M. BAKER 4204 BALTIMORE ST., 21227									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Right lung collapse</u> (c) <u>METASTATIC CARCINOMA of COLON</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>2/15/82</u> , 19 <u>82</u> , to <u>5/6</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/6/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Herbert Swarbe						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/6/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT SWARBE						22e. ADDRESS S. Baltimore General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 05-10-82		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PK. A.A. MARYLAND							
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.						25a. DATE REC'D. BY REGISTRAR MAY 7 1982		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 8 4 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) ROSE H. BALDER					2a. DATE OF DEATH MONTH DAY YEAR 05-26-82			2b. HOUR 10:50AM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-23-1988		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GERIATRIC HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2601 MADISON AVE. #21217					
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM BALDER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE ROBINSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. 18-46-8856 UNKNOWN		17. INFORMANT JOHN M. BALDER 707 N. CALVERT ST. BALTO., MD 21202					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBRO-VASCULAR ACCIDENT 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) ACCELERATED HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ASCVD, Atrial fibrillation											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 09-08 , 19 81 , to 05-26 , 19 82 , that (I) (we) lost saw the deceased alive on 05-06 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE [Signature]				22c. DATE SIGNED 05-26-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bo ZAW-WIN, M.D.				22e. ADDRESS LEVINDALE GERIATRIC CTR BALTO 21215							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 27, 1982		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION BALTIMORE COUNTY MARYLAND					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25. DATE READ BY REGISTRAR MAY 28 1982 REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 1 7 8 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST HENRY		MIDDLE L.		LAST BALLARD		2b. DATE OF DEATH MONTH DAY YEAR MAY 21 82	
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 9 29 1926		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7b. HOUR 7:00A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VAMC, LOCH RAVEN BLVD. BALTO. MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Robert Hall	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Carney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4 Altura Ct., Apt. A1	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Lloyd Ballard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Blair		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II		16b. SOCIAL SECURITY NO. 217-20-1851		17 INFORMANT ADDRESS (21234) A1 Shirley M. Ballard, 4 Altura Ct. Apt.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cardiac arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Ca of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) COPD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 18mo 10-15 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that X (this hospital) attended the deceased from MAY 18, 1982, to MAY 21, 1982, that X (we) last saw the deceased alive on May 21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above X (we) (did) (not) view the body after death.									
22b. SIGNATURE Kessler-Raub m		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/21/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kessler-Raub m		22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTO. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-24-82		23c. NAME OF CEMETERY OR CREMATORY Holly Hills Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto., Md.			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home, Inc.		ADDRESS 7401 Belair Rd.		25a. DATE BY REGISTRAR MAY 26 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

CONFIDENTIAL



1. The first part of the document is a letterhead consisting of the word "CONFIDENTIAL" in large, bold, capital letters. Below this, there is a line of smaller text that reads "ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED".

2. The second part of the document is a series of numbered paragraphs. The first paragraph begins with "1. The first part of the document is a letterhead..." and continues with a description of the document's content. The second paragraph begins with "2. The second part of the document is a series of numbered paragraphs..." and continues with a description of the document's content. The third paragraph begins with "3. The third part of the document is a series of numbered paragraphs..." and continues with a description of the document's content.

3. The third part of the document is a series of numbered paragraphs. The first paragraph begins with "1. The first part of the document is a letterhead..." and continues with a description of the document's content. The second paragraph begins with "2. The second part of the document is a series of numbered paragraphs..." and continues with a description of the document's content. The third paragraph begins with "3. The third part of the document is a series of numbered paragraphs..." and continues with a description of the document's content.

4. The fourth part of the document is a series of numbered paragraphs. The first paragraph begins with "1. The first part of the document is a letterhead..." and continues with a description of the document's content. The second paragraph begins with "2. The second part of the document is a series of numbered paragraphs..." and continues with a description of the document's content. The third paragraph begins with "3. The third part of the document is a series of numbered paragraphs..." and continues with a description of the document's content.

5. The fifth part of the document is a series of numbered paragraphs. The first paragraph begins with "1. The first part of the document is a letterhead..." and continues with a description of the document's content. The second paragraph begins with "2. The second part of the document is a series of numbered paragraphs..." and continues with a description of the document's content. The third paragraph begins with "3. The third part of the document is a series of numbered paragraphs..." and continues with a description of the document's content.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer's death certificate.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 7 8 6	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST JAMES MIDDLE M. LAST BALTZLEY James M. M. BALTZLEY				MONTH DAY YEAR HOUR 5-21-82 5:45 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH	
				MONTH DAY YEAR June 23, 1901	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		6. AGE (IN YEARS LAST BIRTHDAY) 80	
		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator	
13a. STATE Maryland		13b. COUNTY Balto		12b. KIND OF BUSINESS OR INDUSTRY B G & E	
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Martha		13c. STREET ADDRESS 1510 Kirkwood Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 705-03-6166		17. INFORMANT ADDRESS Martha B. Hyatt, 1409 Woodbridge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 } DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROSIS (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE, COPD,					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
22a. I certify that (I) (this hospital) attended the deceased from 5-17-82, to 5-21-82, that (I) (we) lost saw the deceased alive on 5-21-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Geetha Raja		DEGREE RESIDENT PHYSICIAN <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEETHA RAJA		22e. ADDRESS 900 CATON AVE BALTIMORE MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/24/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Witzke Catonsville Funeral Home, P.A. 21228		25a. DATE REC'D. BY REGISTRAR MAY 21 1982		25b. REGISTRAR'S SIGNATURE Rene J. [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH ESTIMATED <input type="checkbox"/>		DAY		YEAR		2b. HOUR					
Charlie						Banks		5		14		19		82		a m					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED		MONTH		DAY		YEAR		2d. HOUR	
Male		Black		9 4 1879		102 YRS.						5		14		19		82		11:40 a m	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
BALTIMORE		USA						Baltimore City,													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		607 McCabe Avenue																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		607 MCCABE AVENUE													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
WILLIAM		EMILY																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		212-18-3013		GEORGE BANKS		347 EUDOWOOD LANE															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (c) stating the under- lying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Carcinoma of bladder																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 5/14/82																	
ACTUAL SIGNATURE Thomas D. Smith		MEDICAL EXAMINER																			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE											
BURIAL		5/18/82		PLEASANT REST CEM.		TOWSON		MD													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
WM. C. MARCH F/H 1101		E. NORTH AVENUE		MAY 17 1982		Thomas D. Smith															

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 5, 6 g567 5/24/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 1 7 8 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nathan Banks Jr.		2a. DATE OF DEATH MONTH DAY YEAR May 7, 1982		2b. HOUR M M	
3. SEX Male		4. RACE Blk		5. DATE OF BIRTH MONTH DAY YEAR 5-28-23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 58 59	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1523 N. Appleton St.		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1523 N. Appleton St.			
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Banks Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Buriel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 228-18-1430		17. INFORMANT ADDRESS Ruth Banks 1523 N. Appleton St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4029 Hypertension Cardiovascular IMMEDIATE CAUSE (a) Hypertension Cardiovascular DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____	
22a. I certify that (I) (this hospital) attended the deceased from 9/13/80 to 5/7/82 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE WAYLAND E. JONES, M.D.		DEGREE PHYSICIAN and SURGEON		22c. DATE SIGNED 5/10/82	
22d. PHYSICIAN'S NAME (PRINT) Wayland E. Jones		22e. ADDRESS 1523 N. Appleton Ave. Baltimore, Md. 21201			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/13/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md					
24. FUNERAL DIRECTOR NAME Veron R. Bailey		ADDRESS 1348 N. Calhoun St.		25a. DATE REC'D. BY REGISTRAR MAY 11 1982	
25b. REGISTRAR'S SIGNATURE James J. Norton					

Burial

2/2/5

Yonkers Co.

Police

WAYLAND E. JONES, M.D.

PHYSICIAN AND SURGEON

1100 N. FREMONT AVE.

BALTIMORE, MD. 21217

NO

206-16-242

TRUST BANKS

1523 N. WASHINGTON ST.

Jackson

Danks St.

Thomas

Baltimore

1523 N. WASHINGTON ST.

Burial

Baltimore

1523 N. WASHINGTON ST.

VA

U.S.A.

City

DLA

4-2-28-23

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Heenan

Danks St.

May 7, 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 8 2 1 1 7 8 9									
1- FOR STATE REGISTRAR Joseph L. Banzhoff CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) JOSEPH L. BANZHOFF						2a. DATE OF DEATH MONTH 5 DAY 19 YEAR 82		2b. HOUR 10.30 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 12 DAY 29 YEAR 23		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN'L HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRAIN OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A.				13c. CITY OR TOWN BALTIMORE		13d. STREET ADDRESS 5822 REDMOND ST. (21225)			
14. FATHER'S NAME FIRST JOHN MIDDLE BANZHOFF LAST BANZHOFF				15. MOTHER'S MAIDEN NAME FIRST OLIVE MIDDLE HYDE LAST HYDE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 190 123917		17. INFORMANT ADDRESS IONA BANZHOFF (SAME AS 13E)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 1991 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (he) (this hospital) attended the deceased from 4-23 , 19 82 , to 5-19 , 19 82 , that (I) (we) last saw the deceased alive on 5-19 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.									
22b. SIGNATURE Soc Witkiol, M.D.				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Soc Witkiol, M.D.				22e. ADDRESS 3301 SO. HANOVER STREET					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/20/82		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL		23d. LOCATION CITY OR TOWN BALTO. COUNTY MD. STATE MD.			
24. FUNERAL DIRECTOR NAME BALTO. MD. 21225 ADDRESS GONCE FUNERAL HOME 4001 RICHIE HWY				25a. DATE REC'D. BY REGISTRAR MAY 20 1982 25b. REGISTRAR'S SIGNATURE James J. Nathan					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11790	
1. DECEASED NAME (TYPE OR PRINT) Thomas Barbey						2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 5 31 19 82		2b. HOUR M 6:30 P. M.			
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 1 17 52 30	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS 30	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD 5 31 19 82		7d. HOUR M 6:30 P. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) auto mechanic		12b. KIND OF BUSINESS OR INDUSTRY Towson Val.			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Perry Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9318 Snyder Lane (21128)			
14. FATHER'S NAME FIRST MIDDLE LAST John E. Barbey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty M. Mohr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 215-56-4345		17. INFORMANT ADDRESS (21128) John E. Barbey, 9318 Snyder Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9803 IMMEDIATE CAUSE (a) Acute Desipramine Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/21/1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject ingested drug						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ?		21f. LOCATION STREET ? CITY OR TOWN ? COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 6-1-82					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-2-82		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION Westview Balto. Md.					
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home, Inc.			ADDRESS 7401 Belair Rd.			25a. DATE REC'D. BY REGISTRAR JUN 7 1982		25b. REGISTRAR'S SIGNATURE			

11-11-58

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 7 9 1	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Larry (BABY BOY) Eugene Barksdale Jr.					2a. DATE OF DEATH MONTH DAY YEAR May 21, 1982			2b. HOUR 12:15 AM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 8 82		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 12		IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1608 N. Broadway			
14. FATHER'S NAME FIRST MIDDLE LAST Larry Eugene Barksdale					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Silver						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Barbara Silver 1608 N. Broadway							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 0418 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RENAL AND HEPATIC FAILURE (c) BACTERIOIDES SEPSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5d 11d											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION 5/16/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Possible Intra Abdominal Process				20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/8/82 , 19 82 , to 5/21 , 19 82 , that (I) (we) last saw the deceased alive on 5/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death).											
22b. SIGNATURE D. Virshup					DEGREE		22c. DATE SIGNED 5/21/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. VIRSHUP					22e. ADDRESS JOHNS HOPKINS HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/28/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.					25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 9 2

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) MARY E. BARNARD		MONTH DAY YEAR 5/18/82 5 18 82		10.43A _M	
3. SEX F Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS 35 E. 25th Street	
14. FATHER'S NAME FIRST MIDDLE LAST Frank --- Best		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie --- Leatherwood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-22-1741		17. INFORMANT ADDRESS 4 Arthur Ave. Balt, Md 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 5/13/82 , to 5/18/82 , that (1) <input checked="" type="checkbox"/> I saw the deceased give an 5/18/82 opinion death occurred on the date and hour and from the causes stated above, (2) <input checked="" type="checkbox"/> I did not view the body after death.					
22b. SIGNATURE Bhupinder Singh		DEGREE MD		22c. DATE SIGNED 5/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BHUPINDER SINGH		22e. ADDRESS NORTH CHARLES GEN HOSP. BALTO MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/21/82		23c. NAME OF CEMETERY OR CREMATORY Security Process	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore, Md.		23e. DATE REC'D BY REGISTRAR MAY 24 1982			
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, Md		25b. REGISTRAR'S SIGNATURE Rhonda J. [Signature]	

2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11793	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. HOUR		
CHARLIE H. BARNES						5-26-82			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
M	BLACK	Dec 17 1915	66 YRS.			5-26-82			M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
WAGNER VA			U. S. A						Baltimore City		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			221 N. Fremont Avenue			RETIRED					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MARYLAND						BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
UNKNOWN			UNKNOWN			217035083			MRS. SARAH CRAIG 1009 W. LAFFAYETTE AVE		
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16c. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
YES			WILLI								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE			SIGNED		
Margarita A. Korell, M.D.			Assistant			5-27-82					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			6-2-82			CROWN HILL V. A. CEM.			CROWN HILL BALTO MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
JESSIE L. BURG			2222 W NORTH AVE			MAY 28 1982			Renee Jan Nether		

MEDICAL CERTIFICATION

11.11.93

11.11.93



11.11.93

11.11.93

11.11.93



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 9 4

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CHESTER				BARNETT	5		18	82	5:25 P.		M
3. SEX	M	4. RACE	B	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				MONTH DAY YEAR 03 08 15		67		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Preston Co., N.C.	USA				City MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Balto		North Charles Gen. Hosp.									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				Balto.				3010 Auchentroy Ter.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Willey		FIRST MIDDLE LAST Lousianna									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
Yes		226-10-5057		Pearl Barnett 3010 Auchentroy Ter.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF METASTATIC CARCINOMA STOMACH (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Bhupinder Singh		MD						5/18			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
BHUPINDER SINGH		N.C.G.H. BALTO MD 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5-24-82		Crownsville Vet. Cem.		Crownsville Md.					
24. FUNERAL DIRECTOR NAME		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leroy O. Dyett		4600 Liberty		MAY 20 1982		Name					

100-100000

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing military operations or administrative matters.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 1 7 9 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)					3a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
ROSE F. BARNETT					5/31/82		5:50 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR MONTHS DAYS	
FEMALE		BLACK		10 6 1902		80 YRS.			
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U. S. A.				BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		Greater Penn. Ave Nursing Home				DOMESTIC		Pvt. FAMILY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
Md.					BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Unknown					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT					
NO		212-32-4659		BALTIMORE ADDRESS MARYLAND 21217 REV. MARION BASCOM 1325 MADISON AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Cerebral-vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Suprasellar Aneurysm									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 Part 1 or Part 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-29-1982, to 5-31-1982, that (I) (we) last saw the deceased alive on 5-31-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
R. D. CROSLLEY				1235 E. Monument St Balto					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6/4/82		Anodus Mem. Park		BALTIMORE County, MARYLAND			
24. FUNERAL DIRECTOR		BALTIMORE		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Herbert E. Nutter Funeral Home		3035 W. NORTH AVE		JUN 7 1982		Name Jan [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 7 9 6

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret M Barranco			2a. DATE OF DEATH MONTH DAY YEAR May 21, 1982		2b. HOUR 1:50 am
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 4, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE CITY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 427 E. FORT AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS A WILLIAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE — MRCORMICK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-20-5345	17. INFORMANT ADDRESS CHARLES F. BARRANCO (SAME AS 13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 1749 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Metastatic Adenocarcinoma of Breast and Colon DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 19 82, to May 21 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 21 82, and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.					
22b. SIGNATURE Sheik Rhodes MD.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-21-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheik Rhodes MD.		22e. ADDRESS C/O Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAY 24, 1982	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	23e. DATE REC'D. BY REGISTRAR MAY 25 1982
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		ADDRESS 501 RITCHIE HWY. SEVERNA PARK, MD		25a. DATE REC'D. BY REGISTRAR MAY 25 1982	

25b. REGISTRAR'S SIGNATURE
James J. [Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11797	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST MIDDLE LAST Mark Sean Barrett										2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 18 1982	
3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 7. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED WIDOWED DIVORCED										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 18 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED WIDOWED DIVORCED										9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY										Baltimore City, MD.	
13a. STATE 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS? YES NO 13d. STREET ADDRESS										Maryland Harford Forest Hills YES NO 305 Bynum Ridge Road	
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										Charles Barrett Elaine Fabian	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS										No 220-68-2752 Charles Barrett 305 Bynum Ridge Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral Trauma 8232 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										11:50 P.M. 5 17 1982 Motorcyclist impacted fixed object	
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE										parking lot Rt. 24 & Bynum Rd., Belair, Harford Co., Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner											
ACTUAL SIGNATURE TITLE (SPECIFY) M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED										Virginia L. Dolan 5-18-82	
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS										Virginia L. Dolan, M.D. 111 Penn Street	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE										Burial 5-22-82 St. Stephen's Cem. Lehman, Luzerne Co., Pa.	
24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE										C.S. Zeiler & Son Inc. 901 S. Conkling Street MAY 20 1982 Frances Jan Weather	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 7 9 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Blaine Bates</u>				2a. DATE OF DEATH MONTH <u>5</u> DAY <u>18</u> YEAR <u>82</u>			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>10</u> DAY <u>1</u> YEAR <u>14</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore City Hospitals</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Plant Mgr.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Harris Steel</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <u>508 S. Quail Street 21224</u>	
14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>Bates</u> LAST <u>Prudence</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Prudence</u> MIDDLE <u>Smith</u> LAST <u>Smith</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>213-09-2189</u>		17. INFORMANT ADDRESS <u>Catherine M. Bates 508 S. Quail Street</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of colon.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from <u>5/17</u> , 19 <u>82</u> , to <u>5/18</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE <u>James P. Zeiler</u>				DEGREE		22c. DATE SIGNED <u>5/19</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James P. Zeiler MD</u>				22e. ADDRESS <u>6224 Eastern Ave 21224</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5-22-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Eastwood, Balto Co. Md.</u>	
24. FUNERAL DIRECTOR NAME <u>C.S. Zeiler & Son Inc.</u> ADDRESS <u>6224 Eastern Avenue</u>				25. DATE REC'D. BY REGISTRAR / REGISTRAR'S SIGNATURE <u>MAY 20 1982</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER'S OFFICE BY TELEPHONE. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 TO THE FUNERAL HOME. PAGES 5 AND 6 TO THE BUREAU OF VITAL RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN INTERSTATE DEATH RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 200 WEST BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

REG. NO. 11799

DHMH-17
(VR A15 ME (5))
15M 2/80

DATE REC'D. BY REGISTER
MAY 18 1982

2029-01-01 10:00 AM

ALFRED W. DAWSON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 0 0

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JAMES H. BAUCOM			2a. DATE OF DEATH MONTH DAY YEAR 5-7-1982		2b. HOUR 3 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-7-1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14 S. POPPLETON ST. 21201		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 14 S. Poppleton St. 21201	
14. FATHER'S NAME FIRST MIDDLE LAST John Baucom		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Therrie Ingram			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II 245-14-5384		17. INFORMANT ADDRESS Jeff Baucom Rt 1 Crown Point 37650	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac - pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) CA pharynx & alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last 1490					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/4 19 82 , to 5/7 19 82 , that (I) (we) last saw the deceased alive on 5/4 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rumma		DEGREE MD		22c. DATE SIGNED 5/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUMMA AMORNMARN		22e. ADDRESS UNIVERSITY OF MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 5-13-1982	23c. NAME OF CEMETERY OR CREMATORY Life Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crown Point Tennessee	
24. FUNERAL DIRECTOR John J. Conant & Son Inc. 901 Hollins St.		25a. DATE RECD. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 8 0 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Earle Walter Bauer EARLE BAUER			2a. DATE OF DEATH MONTH May DAY 25 YEAR 1982 HOUR 9.25 AM		
3. SEX Male	4. RACE White	5. JAN. OF BIRTH MONTH 01 DAY 07 YEAR 1901	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Relay, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE HOSP		12a. USUAL OCCUPATION (IF WORKING) Ret. Builder	12b. KIND OF BUSINESS OR INDUSTRY Self-Emp.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md	13b. CITY OR TOWN A.A.	13c. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS 21090 703 ANDOVER Road		
14. FATHER'S NAME FIRST Louis MIDDLE Bauer LAST Mary	15. MOTHER'S MAIDEN NAME FIRST Friedricka MIDDLE Pfitzmaier LAST Same as #13				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (TOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 212-16-8844	17. INFORMANT (wife) ADDRESS Mrs. Bessie R. Bauer			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarct (c) Coronary artery disease, severe			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/1 19 73 , to 5/25 19 82 , that (I) (we) lost saw the deceased alive on 5/20 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. F. Awalt		DEGREE MD		22c. DATE SIGNED 5/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L F AWALT, MD		22e. ADDRESS 3001 S. HANOVER ST BALTIMORE, MD 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May. 28, 1982	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME P. Chaitin ADDRESS Singleton Funeral Home Green Burnie Md.		25a. DATE REC'D. BY REGISTRAR MAY 28 1982		25b. REGISTRAR'S SIGNATURE Kim Jan North	

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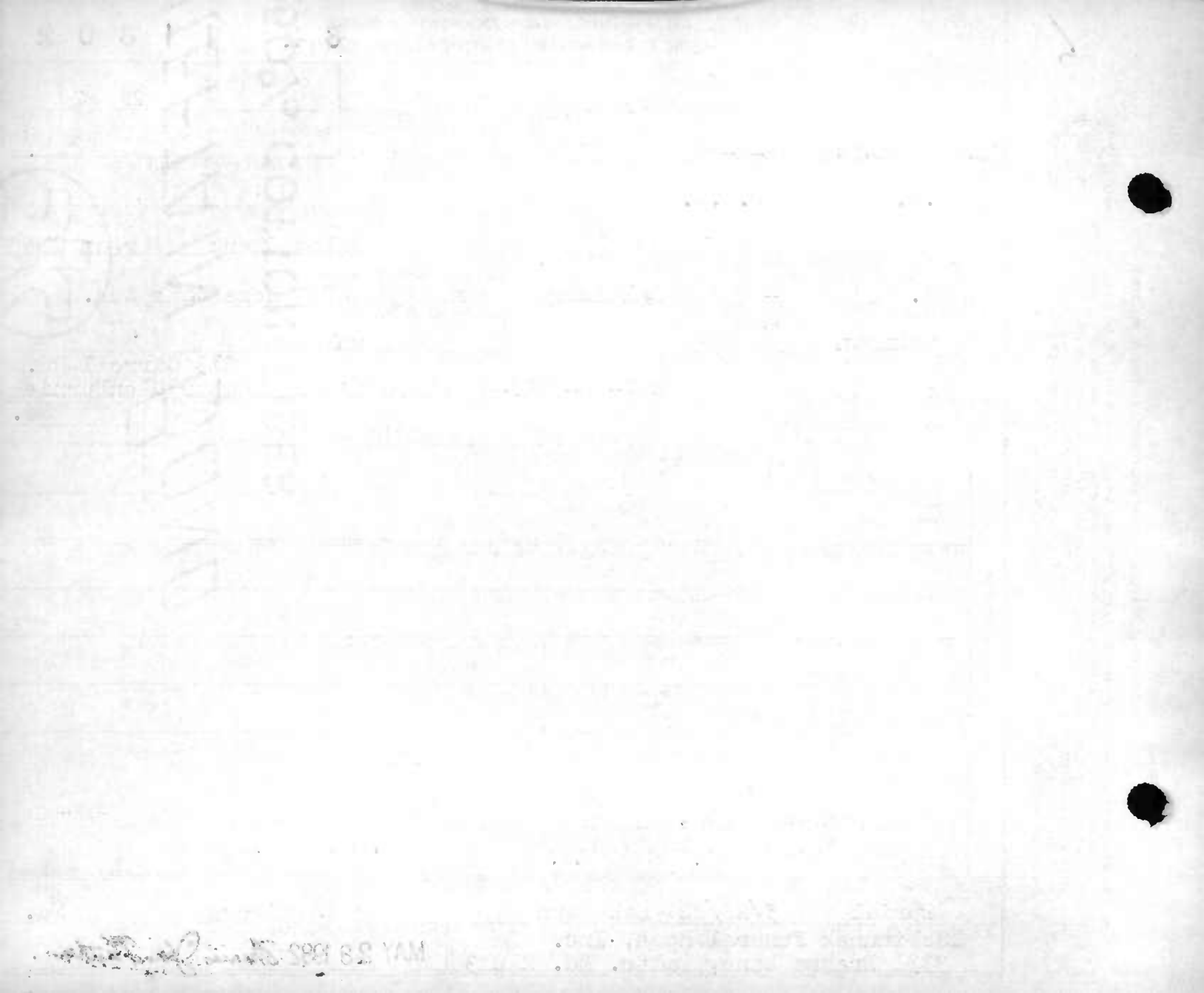
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11802

1- FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE OF DEATH		22. DATE OF DEATH		23. DATE OF DEATH		24. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		2. DATE OF DEATH		2. DATE OF DEATH		2. DATE OF DEATH		2. DATE OF DEATH	
Thelma Mary Bauer		5 25 1982		5 25 1982		5 25 1982		5 25 1982		5 25 1982	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR	14. MIN.
female	white	2-2-05	77 YRS.			5 25 1982					
15. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	16. CITIZEN OF WHAT COUNTRY?	17. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		18. BALTIMORE CITY OR COUNTY OF DEATH		19. BALTIMORE CITY OR COUNTY OF DEATH		20. BALTIMORE CITY OR COUNTY OF DEATH		21. BALTIMORE CITY OR COUNTY OF DEATH	
N.J.	U.S.A.			Baltimore City,		Baltimore City,		Baltimore City,		Baltimore City,	
22. CITY OR TOWN OF DEATH	23. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	24. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		25. KIND OF BUSINESS OR INDUSTRY		26. KIND OF BUSINESS OR INDUSTRY		27. KIND OF BUSINESS OR INDUSTRY		28. KIND OF BUSINESS OR INDUSTRY	
Baltimore	4753 Homesdale Avenue	Sales Clerk		Dress Shop		Dress Shop		Dress Shop		Dress Shop	
29. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		30. STATE		31. COUNTY		32. CITY OR TOWN		33. INSIDE CITY LIMITS?		34. STREET ADDRESS	
Md.		-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4753 Homesdale Ave.		4753 Homesdale Ave.	
35. FATHER'S NAME		36. MOTHER'S MAIDEN NAME		37. MOTHER'S MAIDEN NAME		38. MOTHER'S MAIDEN NAME		39. MOTHER'S MAIDEN NAME		40. MOTHER'S MAIDEN NAME	
unknown		unknown		unknown		unknown		unknown		unknown	
41. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		42. SOCIAL SECURITY NO.		43. INFORMANT		44. ADDRESS		45. ADDRESS		46. ADDRESS	
no		217-12-7240-A		Clara O'Hara (dghtr)		Glen Burnie		Glen Burnie		Glen Burnie	
47. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		48. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		49. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		50. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		51. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		52. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular		IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular		IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular		IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular		IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular		IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular	
Disease		Disease		Disease		Disease		Disease		Disease	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
53. DATE OF OPERATION		54. CONDITION FOR WHICH OPERATION WAS PERFORMED?		55. DATE OF OPERATION		56. CONDITION FOR WHICH OPERATION WAS PERFORMED?		57. DATE OF OPERATION		58. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
		19									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
23. ACTUAL SIGNATURE		24. TITLE (SPECIFY)		25. DATE SIGNED		26. DATE SIGNED		27. DATE SIGNED		28. DATE SIGNED	
Virginia L. Dolan		Assistant		5-25-82		5-25-82		5-25-82		5-25-82	
29. EXAMINER'S NAME (TYPE OR PRINT)		30. ADDRESS		31. ADDRESS		32. ADDRESS		33. ADDRESS		34. ADDRESS	
Virginia L. Dolan, M.D.		111 Penn Street		111 Penn Street		111 Penn Street		111 Penn Street		111 Penn Street	
35. BURIAL, CREMATION, REMOVAL (SPECIFY)		36. DATE		37. NAME OF CEMETERY OR CREMATORY		38. LOCATION CITY OR TOWN		39. COUNTY		40. STATE	
Burial		5/28/82		Oak Lawn		Baltimore		Baltimore		Md.	
41. FUNERAL DIRECTOR NAME		42. ADDRESS		43. DATE REC'D. BY REGISTRAR		44. REGISTRAR'S SIGNATURE		45. REGISTRAR'S SIGNATURE		46. REGISTRAR'S SIGNATURE	
Schimunek Funeral Home, Inc.		3331 Brehms Lane, Balto. Md. 21213		MAY 28 1982		Charles J. Van Thullen		Charles J. Van Thullen		Charles J. Van Thullen	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 8 0 3			
1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THADDEUS C. BAUTRO				2a. DATE OF DEATH MONTH DAY YEAR 5-15-82		2b. HOUR 3:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 21 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION OF DECEASED (IF OTHER THAN LAST, GIVE LIFE) Hunting & Fishing		12b. KIND OF BUSINESS OR INDUSTRY Slope	
13a. STATE MD				13b. CITY OR TOWN PARKVILLE		13c. STREET ADDRESS 8423 Hallmark Circle	
14. FATHER'S NAME FIRST MIDDLE LAST Adam BAUTRO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STELLA Rybacki			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-05-5184		17. INFORMANT ADDRESS Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 6 19 82 , to MAY 15 19 82 , that (I) (we) lost 5-15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Varipap MD				DEGREE MD		22c. DATE SIGNED 5/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT VARIPAP MD.				22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 5/18/82		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME EVANS Funeral Chapel				25a. DATE REC'D. BY REGISTRAR MAY 21 1982		25b. REGISTRAR'S SIGNATURE Thomas J. ...	

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THIDEN

UNION CITY

UNION MEMORIAL HOSPITAL

ALBANY

12-2-54

12-2-54

12-2-54

Respiratory

copy

12-2-54



UNION MEMORIAL HOSPITAL

VARIPAR NO.

ROBERT

12-2-54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 8 0 4	
FOR 1 - STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence A. Bayline</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>May 14, 1982</i>			2b. HOUR M <i>M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 8, 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS <i></i>		IF UNDER 24 HRS. HOURS MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>319 E. Hamburg St. Balto. Md.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Maryland</i>		13b. COUNTY <i></i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>319 E. Hamburg St. Balto. Md.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Edgar O. Jenkins</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Susan Appel</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-42-3619</i>		17. INFORMANT ADDRESS <i>Ms. Joan Ryan, Same as above</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>liver metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>renal cell carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>1890</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>dehydration, malnutrition, malignant ascites</i>											
19a. DATE OF OPERATION <i>4-22-82</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Levin shunt placement for</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <i>2:30 P.M. 5 14 1982</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i></i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i></i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i></i>							
22a. I certify that (1) this hospital attended the deceased from <i>Nov</i> 19 <i>81</i> , to <i>May 14</i> 19 <i>82</i> , that (1) (we) lost saw the deceased alive on <i>May 5</i> 19 <i>82</i> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Lalah Newbrough</i>						DEGREE <i></i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/14/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lalah Newbrough</i>				22e. ADDRESS <i>1211 Wall St. Balto 21230</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 17, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 17 1982</i>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONARD O. BEAM SR.			2a. DATE OF DEATH MONTH DAY YEAR 5 23 82		2b. HOUR 12 01 P.M.
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6 27 12		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY SELF
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN BALT.		13c. STREET ADDRESS 3418 ROYCE AVE.
14. FATHER'S NAME FIRST MIDDLE LAST LEONARD O. BEAM			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA SMITH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-10-7179A		17. INFORMANT ADDRESS FLORENCE E. BEAM (SAME)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) ASCVD gave rise to immediate } cause (a), stating the } underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ca of the Bladder					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 5-23-82 to 5-23-82, to 5-23-82, that (I) (we) lost saw the deceased alive on 5-23-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M. Ordoqui		DEGREE M.D.		22c. DATE SIGNED 5-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Ordoqui		22e. ADDRESS SINAI HOSPITAL BALT. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5-24-82		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PK.	
23d. LOCATION CITY OR TOWN COUNTY STATE CATONVILLE BALTO. MD.		24. FUNERAL DIRECTOR NAME FRANK H. NEWELL, INC.		25a. DATE REC'D. BY REGISTRAR MAY 25 1982	
25b. REGISTRAR'S SIGNATURE [Signature]					

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WATER-PROOF
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WATER-PROOF
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 8 0 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy V. BECKER				2a. DATE OF DEATH MONTH DAY YEAR 5 12 82			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 03 28 15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALTIMORE GEN'L HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN MD BALTIMORE BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 105 W. OSTEND ST	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE F. VOLKMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY W. SCHMIDT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212 093511		17. INFORMANT ADDRESS RT. Cooke MD SBGH Hosp.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 4-14 , 19 82 , to 5-12 , 19 82 , that (I) (we) lost saw the deceased alive on 5-12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Sol Witrol, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED MAY 12, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOL WITROL, M.D.				22e. ADDRESS 3301 So. HANOVER ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 14, 1982		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME McLully Funeral Home, 130 E. Fort Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 1 1 8 0 7	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
MARY ETTA (Beitcher) BELCHER			05-07-82		3:25pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female	BLACK	5 19 98	8.3		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Nutbush, VA.	U.S.A.		CITY			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO	Church Home + Hospital		Housewife		Home	
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS		13d. INSIDE CITY LIMITS?	
Md.		BALTO	859 Avondale Rd.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
Albert Cousins Sr			SALLIE Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS	
No		217-56-6133	Mrs. Noel Willis		500 University Pkwy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENO CARCINOMA CARCINOMA OF LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF (b) MEASAS METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 05-04-82 to 05-07-82, that (we) last saw the deceased alive on 05-07-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.						
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
A. F. Nazemi MD				5/7/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
DR. A.F. NAZEMI M.D.		CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE BALTIMORE, MD. 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		5-11-82	Cousin Cem.		VICTORIA, VA.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		
Jas. A. Morton & Sons		1701 LAWRENS		MAY 12 1982		
				REGISTRAR'S SIGNATURE		
				Name Jan Martin		

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May 1 (Baker)

Black 212 18 22

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Dr. J. D. ...
Mr. ...
All ...

No. 1 ...



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2-11-2 ...
A. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 1 8 0 8		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAJOR BELL				2a. DATE OF DEATH MONTH DAY YEAR 5 16 82		2b. HOUR 12:50A.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 31 29^{AR}		6. AGE (IN YEARS LAST BIRTHDAY) 52		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1501 N. Patterson Park Av			
14. FATHER'S NAME FIRST MIDDLE LAST Weldon Bell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Kitchen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 224-34-1890		17. INFORMANT ADDRESS Helen Hill 1501 N. Patterson Pk. Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of the lung									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 10 19 82 , to May 16 19 82 , that <input checked="" type="checkbox"/> (we) saw the deceased alive on above, <input checked="" type="checkbox"/> (we) did not view the body after death, and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated.									
22b. SIGNATURE Robert Fuld MD				DEGREE		22c. DATE SIGNED 5/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT FULD, MD				22e. ADDRESS VAMC, Baltimore, Maryland 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/22/82		23c. NAME OF CEMETERY OR CREMATORY Falls Road Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Kenbridge VA			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner number is indicated at one.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 0 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NENO BELLANTE			2a. DATE OF DEATH MONTH DAY YEAR 05 24 82			2b. HOUR 39 A M									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 02 07		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bedford, Pa.		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
13. CITY OR TOWN OF DEATH Baltimore		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			16. KIND OF BUSINESS OR INDUSTRY Welder						
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland		17b. COUNTY -----		17c. CITY OR TOWN Baltimore		17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17e. STREET ADDRESS 514 S. Lehigh Street 21224							
18. FATHER'S NAME FIRST MIDDLE LAST Philip Bellante				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Scaletta				20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1925				21. SOCIAL SECURITY NO. 577-12-4883		22. INFORMANT Philip Bellante 514 S. Lehigh St. 21224	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)				33. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
34. I certify that (I) (this hospital) attended the deceased from <u>05-07</u> , 19 <u>82</u> , to <u>05-24</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>05-24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
35. SIGNATURE OSMAN MD				DEGREE				36. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		37. DATE SIGNED 05-24-82					
38. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN OSMANSKI MD.				39. ADDRESS BALTO. CITY HOSPITALS											
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				41. DATE 5-26-82		42. NAME OF CEMETERY OR CREMATORY Westview Crematorium				43. LOCATION CITY OR TOWN COUNTY STATE Westview Balto. Co. Md.					
44. FUNERAL DIRECTOR NAME C.S. Zeiler & Son Inc. 6224 Eastern Avenue				45. ADDRESS				46. MAY 25 1982		47. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) James J. Nathan					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the companion pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other treatment, event, or other condition, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 1 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MAY 26, 1982		12:16 ^M	
HARRY JOSIAH BELSTERLING							
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		MONTH DAY YEAR		70 YRS.	
JULY 22, 1911							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
PENNSYLVANIA		U.S.A.				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		JOHNS HOPKINS HOSPITAL		ENGINEER		STEEL MFR.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		BALTO.		LUTHERVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		301 FELTON RD. 21093			
CHARLES A. BELSTERLING		ELIZABETH AMES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
NO		165.09.7267		RICHARD S. VELLIGAN		SAME AS 13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST - ASYSTOLE</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ANOXIC BRAIN DAMAGE</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>3481</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> , 19 <u>82</u> , to <u>5/26</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12:16 AM EST</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE				22c. DATE SIGNED	
Wm. Balke		MD				5/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Wm. BALKE		JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
CREMATION		5/27/1982		GREEN MOUNT CREMATORY		CITY OR TOWN COUNTY STATE	
						BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR			
WALTER BROOKS BRADLEY, INC., DUNDALK, MD. 21222				MAY 28 1982			

REGISTRAR'S SIGNATURE

01811 82

2/10/75

Johns Hopkins Hospital

Mr. Galt

Mr. Galt

and

W. Galt 1st 25

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CAROLINE MARKET - WYOMING

EXHIBITION

ANNUAL CAROLINE MARKET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1 - STATE REGISTRAR					8 2 1 1 8 1 1 REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) JOHN (Benke) BENKER					2a. DATE OF DEATH MONTH DAY YEAR 5-20 82					2b. HOUR 9:15 A					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1908			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marine			12b. KIND OF BUSINESS OR INDUSTRY Service			
13a. STATE Maryland					13b. COUNTY - -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 820 S. East Ave.				
14. FATHER'S NAME FIRST MIDDLE LAST Paul - Benke					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa - Polczynski										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT ADDRESS Marie Benke 820 S. East Ave.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - (c) - DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from July 19 82 to April 19 82 , that (I) (we) last saw the deceased alive on April 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE L. MAMANTA					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 5/20/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. MAMANTA					22e. ADDRESS 4940 EASTERN AVE										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE May 24, 1982		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus			23d. LOCATION CITY OR TOWN COUNTY STATE - - Baltimore Co., Md.					
24. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc.					ADDRESS 700 S. Con kling St.			25. DATE RECD. BY REGISTRAR MAY 21 1982 REGISTRAR'S SIGNATURE Thomas J. Smith							

with

Ballantine Co., N.Y.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 1 1 8 1 2		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cyril S Bennett										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 1 1982		2b. HOUR M M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 16 03	6. AGE (IN YEARS) (LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 1 1982		2d. HOUR M 1:48 P M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) pressman		12b. KIND OF BUSINESS OR INDUSTRY C&B Co					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1712 Glen Curtis Rd				
14. FATHER'S NAME FIRST MIDDLE LAST unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 09 7577		17. INFORMANT ADDRESS Ellen Gott 1712 Glen Curtis Rd								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia by aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Arteriosclerotic Cardiovascular Disease</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5 1 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject choked while eating								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7232 Germanhill Rd., Dundalk, Balto. Co., Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 5-2-82				
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/5/82		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md						
24. FUNERAL DIRECTOR NAME Walter Dabrowski				ADDRESS 1005 Dundalk Avenue		25a. DATE REC'D. BY REGISTRAR MAY 10 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. Kathan</u>				

80% COTTON FIBER
MADE IN U.S.A.

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x 1712 Glen Curtis Rd

Baltimore Maryland

unknown

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212 09 7577 Ellen Cott 1712 Glen Curtis Rd

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Burial

1002 Dundalk Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	1	1	8	1	3
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) WARREN BENNETT										2a. DATE OF DEATH MONTH MAY DAY 25 YEAR 1982						
3. SEX MALE										2b. HOUR 2:30 PM						
4. RACE WHITE										6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.						
5. DATE OF BIRTH 12/10/11 MONTH 12 DAY 10 YEAR 11										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.										7b. CITIZEN OF WHAT COUNTRY? U.S.						
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE CITY										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hosp.						
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic										12b. KIND OF BUSINESS OR INDUSTRY Truck						
13a. STATE Md.										13b. COUNTY BALTO.						
13c. CITY OR TOWN Balto.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13e. STREET ADDRESS 1950 Searles Road																
14. FATHER'S NAME FIRST Lesley MIDDLE LAST Bennett										15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE LAST 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 025-12-8499						
17. INFORMANT Mrs. Agnes Hotykay										ADDRESS 1950 Searles Road Balto., Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF THE COLON & METASTASIS TO THE SAGGUM DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 																
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																
22a. I certify that (1) this hospital attended the deceased from May 19 , 19 82 , to May 25 , 19 82 , that (1) (we) last saw the deceased alive on May 25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (he) (she) (it) did not view the body after death.																
22b. SIGNATURE L. M. Jumanoy, M.D.										22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. M. JUMANOY, M.D.										22e. ADDRESS CHURCH HOSPITAL; 100 N. BROADWAY, BALTO.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal										23b. DATE 5/26/82						
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.						
24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.										25a. DATE REC'D. BY REGISTRAR JUN 1 1982						
25b. REGISTRAR'S SIGNATURE [Signature]																

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REPRODUCTION

DATE 11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 8 1 4 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) BEN BERELOWITZ						2a. DATE OF DEATH MONTH DAY YEAR 5-1-82		2b. HOUR 1:30 A.M.			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 2 08		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.					
10. CITY OR TOWN OF DEATH BALT. CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCY BEFORE ADMISSION) 13a. STATE MD. 13a. COUNTY BALTO.		13b. CITY BALTO.		13c. INSIDE CITY ADDRESS NO		13d. STREET ADDRESS 3507 WILD CHERRY RD.					
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS BERELOWITZ				15. MOTHER'S MARRIED NAME FIRST MIDDLE LAST HANNAH UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 411 091581		17. INFORMANT ESTHER BERELOWITZ WIFE		ADDRESS 3507 WILD CHERRY RD. (21207)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST 1850 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC PROSTATE CANCER DUE TO, OR AS A CONSEQUENCE OF (c) 1850										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 5/1 19 82 to 5/1 19 82 , that (we) lost saw the deceased alive on 5/1 19 82 , and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I did) (I did not) (I was not) (I was not) after death.											
22b. SIGNATURE P. S. ORENOWITZ						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/1/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. S. ORENOWITZ						22e. ADDRESS 2435 W. Belvedere Ave 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5-2-82			23c. NAME OF CEMETERY OR CREMATORY JEWISH WAR VETERANS CEM-			23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON						6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)			25a. DATE REC'D. BY REGISTRAR MAY 4 1982		
						25b. REGISTRAR'S SIGNATURE James Santhorn					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 8 1 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN FIRST BERMAN MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR 5/10/82			2b. HOUR 7:45 P			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 09 09 92		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH C. 39 MD.					
10. CITY OR TOWN OF DEATH Bald		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI				SUPERINTENDANT XXXXXX		U.S. POST OFFICE XXXXXX			
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE MD			13b. COUNTY BALTIMORE			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HYMAN XXXXXX BERMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE XXXXXX CHAIT			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO XXXXX					
16b. SOCIAL SECURITY NO. 220441367			17. INFORMANT BERTRAM BERMAN			ADDRESS 6112 RUSK AVE. #21209					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Aspiration, probable DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:45 P.M. 5/10/82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 5/10/82 19, to 5/10/82 19, that (I) (we) last saw the deceased alive on 5/10/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gerald Gantt DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 5/10/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERALD GANTT						22e. ADDRESS SINAI HOSP					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAY 11, 1982		23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH			23d. LOCATION BALTIMORE COUNTY MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.						25a. D. BY MAY 12 1982			25b. REGISTRAR'S SIGNATURE		
6010 REISTERST OWN RD. BALTO., MD 21215											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
Mary W. Berry		5 7 1982			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
female	black	8 MONTH 5 DAY 1906	75 YRS	IF UNDER 24 HRS.	
14. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Florida	USA		Baltimore city MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	1504 E. Oliver Street				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS	
13a. STATE		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1504 E. Oliver Street	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Simon	Harrell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		261-16-2922	James B. Berry 1504 E. Oliver Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Heart Heart Attack					Immediate
2500 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Vascular Disease					Years
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus					Years
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 1981, 19, to Feb 1982, 19, that (I) (we) last saw the deceased alive on Feb 8, 1982, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
N. Sitzmann		MD		5.8.82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
SITZMANN					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/12/82		Eastview Mem Park	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
William C. March F/H 1101 E. North Ave		Baltimore		MAY 11 1982	
		23f. REGISTRAR'S SIGNATURE		23g. REGISTRAR'S SIGNATURE	
				James J. Nathan	

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NOTION FROM

W. A. K. E. L. E. Y

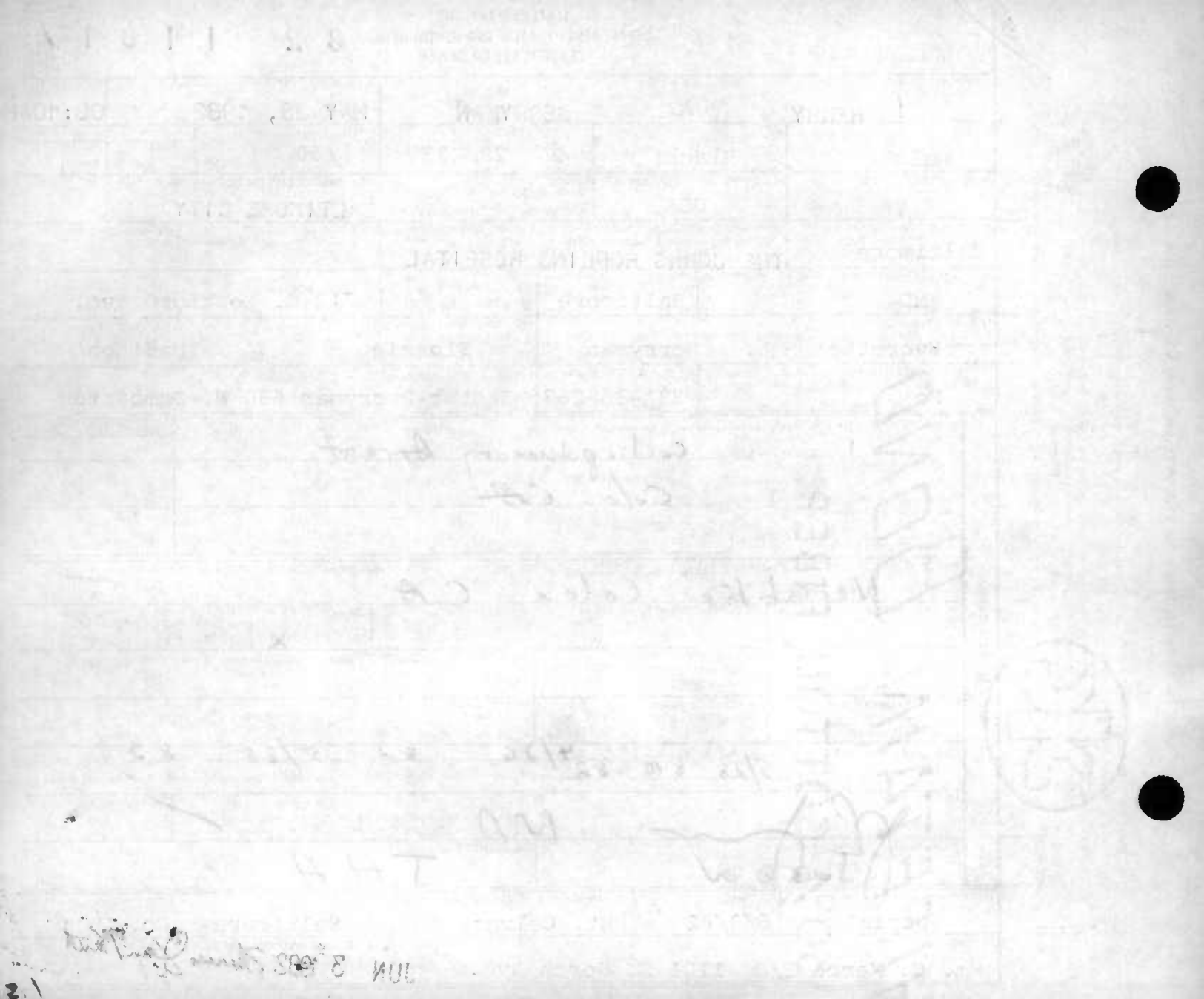


[Faint, mostly illegible handwritten text covering the majority of the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																										
1. FOR STATE REGISTRAR			REG. NO.																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
1			HENRY			A.			BERRYMAN			MAY			28			1982			08:10AM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS											
Male			Black			2 ^{MONTH} 28 ^{DAY} 32 ^{YEAR}			50			YRS.			MONTHS			DAYS			HOURS			MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY			MD.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
Baltimore			THE JOHNS HOPKINS HOSPITAL																							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS														
MD						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			712 N. Montford Ave.														
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																							
FIRST MIDDLE LAST			FIRST MIDDLE LAST																							
Everette L. Berryman			Flossie Madison																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																	
No			231-36-2676			Easter Berryman			638 N. Dumbarton																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 1: DEATH WAS CAUSED BY:																										
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>																										
1539 DUE TO, OR AS A CONSEQUENCE OF																										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																										
(b) <u>Colon CA</u>																										
DUE TO, OR AS A CONSEQUENCE OF																										
(c)																										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																										
<u>Melancholic Colon CA</u>																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																				
			HOUR A.M. MONTH DAY YEAR																							
			P.M. 19																							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION																				
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE																				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> 19 <u>82</u> , to <u>5/28</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/28</u> <u>8:10</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			DATE SIGNED																	
<u>[Signature]</u>			MD																							
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS																							
Jason			J H H																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION																	
Burial			6/3/82			Mt. Calvary Cem.			CITY OR TOWN COUNTY STATE																	
									BALTIMORE Co. MD																	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR																				
NAME ADDRESS			JUN 3 1982			<u>[Signature]</u>																				
Wm. C. March F/H 1101 E. North Ave.																										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	1	1	8	1	8			
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH									
FIRST MIDDLE LAST <i>Rosevelt Betts</i>										MONTH DAY YEAR HOUR <i>5 23 82 9^{PM}</i>									
3. SEX <i>M</i>			4. RACE <i>B</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>9 10 00</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>CITY</i> MD.										
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS									
13a. STATE <i>MD.</i>			13b. COUNTY			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<i>140 Lafayette Ave.</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Betts</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Betts</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>										16b. SOCIAL SECURITY NO. <i>217-09-4709</i>			17. INFORMANT ADDRESS <i>Lottie Downey 48 Gorman Ave.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>DIABETES MELLITUS</i> <i>2506</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gangrene Legs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>5/23 19 82</i> , to <i>5/23 19 82</i> , that (I) (we) lost saw the deceased alive on <i>5/23 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <i>Norman Goldstein</i> MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>5/23/82</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Norman Goldstein</i>										22e. ADDRESS <i>V. Md. Hospital 22 S Greene St Baltimore.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>5/26/82</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landdowns AA Co Md.</i>										
24. FUNERAL DIRECTOR NAME <i>Chas. A Rice FSPA 1300 Eutaw Place</i>										25a. DATE REC'D. BY REGISTRAR <i>JUN 1 1982</i>			25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i>						

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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3

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 2 1 1 8 1 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Irene America Bierman					2a. DATE OF DEATH MONTH DAY YEAR May 24, 1982			2b. HOUR 10:15am		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 30, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2 N. Rose St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland					13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jim Frank Sullivan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah - Tolder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 407-32-0860		17. INFORMANT ADDRESS Susan Fitzpatrick 2 N. Rose St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CA lung metastasis 1629 DUE TO, OR AS A CONSEQUENCE OF (b): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE T.A. Filonow DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.A. Filonow					22e. ADDRESS 223 B. Blvd BALTO MD 21221					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE - - Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. F.H. 1901 Eastern Ave.					25a. DATE REC'D. BY REGISTRAR MAY 28 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Thornton			

0602 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

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DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 1 8 2 0											
1 - FOR STATE REGISTRAR										REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR					
Spencer A. Bishop						5/24/82										7 p.m.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Male		White		4 MONTH 2 DAY 98		84 YRS.				MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Wyoming		U.S.A.				Baltimore City												MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore				St. Agnes Hospital				Construction				Fed. Gov.									
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS													
MD				Anne Arundel		Severn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7917 Citadel Dr.											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
Spencer A. Bishop				Edna Little																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT															
yes				WW I		546-28-0255						Stanley A. Bishop-Severn, Maryland		21144							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 5789 DUE TO, OR AS A CONSEQUENCE OF (b) <u>partial gastrectomy, old</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
				P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>5-24-82</u> , to <u>5-24-82</u> , that (I) (we) last saw the deceased alive on <u>5-24-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED									
<u>Khurram Hanif M.D.</u>												5-24-82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS																	
Khurram Hanif M.D.				5808 MAIN ST. ELKridge Md 21227																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation				May 28, 1982		Westview Crematory				Westview Baltimore MD.											
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)																					
1630 Edmondson Ave. Catonsville, MD. 21228																					
25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE											
MAY 28 1982										<u>Thomas J. Heston</u>											

BP

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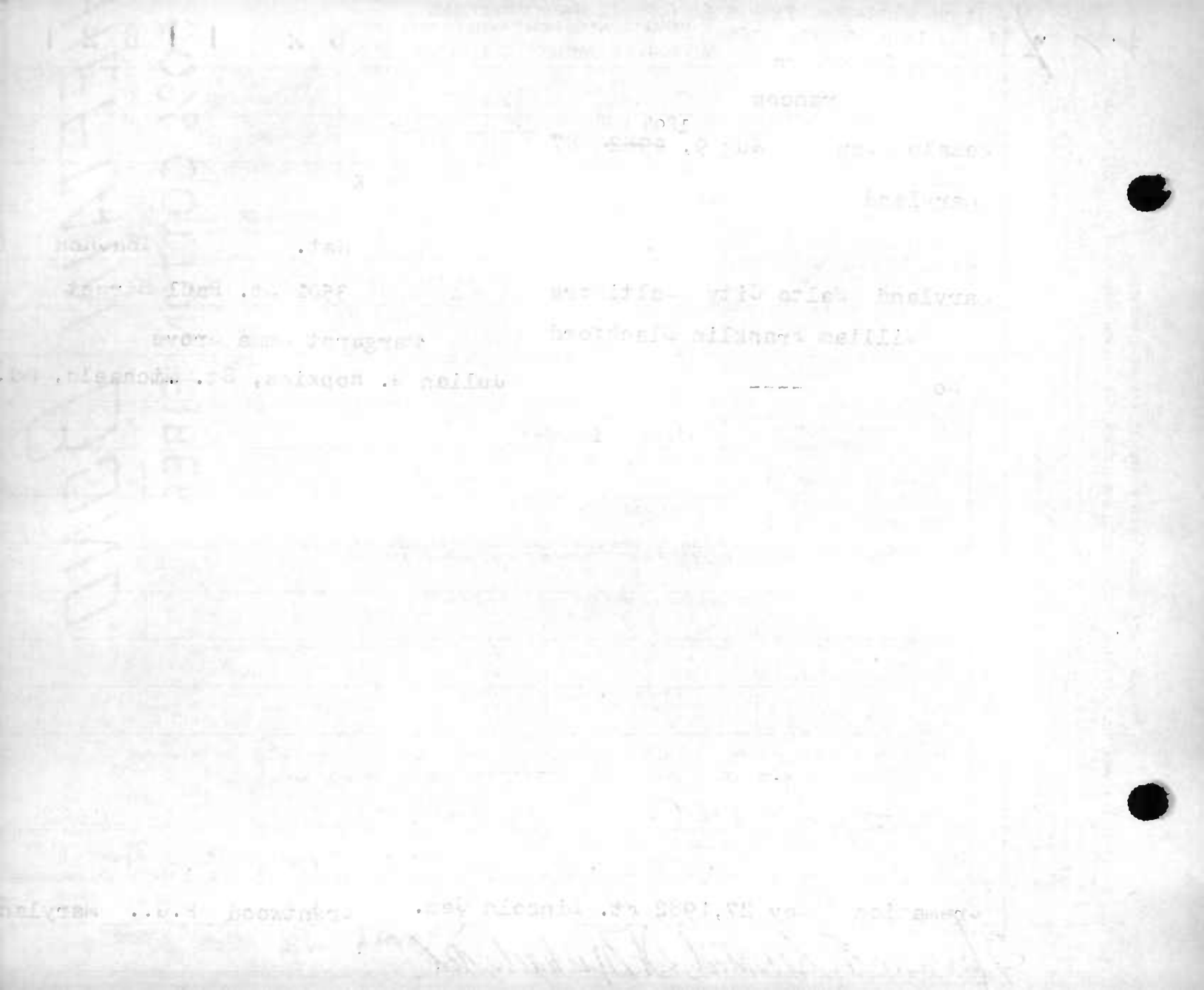


1/10/52

1/10/52

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Frances Pauline Blackford										2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> HOUR <input checked="" type="checkbox"/>	
3. SEX Female 4. RACE Cau 5. DATE OF BIRTH Aug 9, 1982 6. AGE (IN YEARS) 8 7. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD 5 25 19 82 2d. HOUR 1:20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3501 St. Paul Street										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. 12b. KIND OF BUSINESS OR INDUSTRY TEACHER	
13a. STATE Maryland 13b. COUNTY Balto City 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 3501 St. Paul Street	
14. FATHER'S NAME William Franklin Blackford 15. MOTHER'S MAIDEN NAME Margaret Emma Grove											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. ----- 17. INFORMANT Julian G. Hopkins, St. Michaels, Md											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7803 IMMEDIATE CAUSE (a) Seizure Disorder Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.											
19a. DATE OF OPERATION 11/23/82 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Seizure Disorder 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Seizure Disorder 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 23 19 82 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Seizure Disorder											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) At Home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 111 Penn Street, Balto. MD 21201											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Seizure Disorder Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Hormez R. Guard M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED 5/26/82											
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, MD. ADDRESS 111 Penn Street, Balto. MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE May 27, 1982 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G.. Maryland											
24. FUNERAL DIRECTOR Harmon E. Leonard ADDRESS St. Michaels, Md 25. DATED BY REGISTRAR 5/26/82 26. REGISTRAR'S SIGNATURE Harmon E. Leonard											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 1 1 8 2 2 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MATILDA	MIDDLE Barbara	LAST BLAIR	2a. DATE OF DEATH	MONTH 5	DAY 29	YEAR 82	2b. HOUR 1:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 10 DAY 13 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Eastpoint	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7744 Eastdale Road 21224					
14. FATHER'S NAME Killian		15. MOTHER'S MAIDEN NAME Barbara Zeller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 217-12-0336		17. INFORMANT Donald B. Blair 932 Arnccliffe Rd. 21221							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Refractory Shock 4415 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Ruptured Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 3 hrs ~ 3 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ?									
19a. DATE OF OPERATION 5/29		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aortic Aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/28, 19 82, to 5/29, 19 82, that (I) (we) last saw the deceased alive on 5/29, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. Marrone		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/29/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. MARRONE		22e. ADDRESS BALTIMORE City Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-82		23c. NAME OF CEMETERY OR CREMATORY Holly Hills Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River, Balto. Co. Md.			
24. FUNERAL DIRECTOR NAME C.S. Zeiler & Son Inc. 6224 Eastern Avenue				ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE Francis J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 8 2 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Henry W. Blake				2a. DATE OF DEATH MONTH DAY YEAR 05 23 82				2b. HOUR 11:00 A M
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 2 26 06		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland SA	9b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD.				
10. CITY OR TOWN OF DEATH Balt City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt Gen Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. R.R.		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md	13b. COUNTY Balt	13c. CITY OR TOWN Balt	13e. STREET ADDRESS 1731 Petapscost.					
14. FATHER'S NAME FIRST MIDDLE LAST HARRY S. Blake		15. MOTHER'S MAIDEN NAME FIRST LAST Bertha Drewenz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown No		16b. SOCIAL SECURITY NO. 215-03-3072		17. INFORMANT ADDRESS Paul Ackerman 3615 Hickory Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular arrest</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>resp failure + COPD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Intestinal CA of operation subtotal gastrectomy for duodenal ulcer</u>								
19a. DATE OF OPERATION 5/15/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED duodenal ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26/82</u> , 19 <u>82</u> , to <u>5/23</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/23</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE S. H. Meyer		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/23/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. H. Meyer		22e. ADDRESS 3001 S. Hanover St Balt Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Port Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR MAY 24 1982				25b. REGISTRAR'S SIGNATURE Renee J. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 1 1 8 2 4 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edmond		LAST BLAKEY		2a. DATE OF DEATH MONTH DAY YEAR 5 26 82	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 7 94	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuthern Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH City Balto. MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 317548280		17. INFORMANT Chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/10/82, 1982, to 5/26/82, 1982, that (I) (we) last saw the deceased alive on 5/26/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE N. S. ASHOK		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. S. ASHOK		22e. ADDRESS Cuthern Hospital		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/1/82		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. LOCATION CITY OR TOWN COUNTY STATE		23f. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUN 7 1982	
25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Before it may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. The license to remove the body from the hospital, cremation, or removal with the State Dept. of Health and Mental Hygiene. Pages 1 and 2 should be filed with 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8-2 11825							
1. FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) KENNETH Clark BLANCHARD				2a. DATE OF DEATH MONTH DAY YEAR MAY 04 1982				2b. HOUR 02:32AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Scientist - Johns Hopkins School of Medicine		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1 E. Chase Street			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Blanchard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		220 30 3073		17. INFORMANT ADDRESS Thomas Clifford, Ellicott City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>small bowel obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>colon cancer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 minutes</u> <u>10 days</u> <u>1 year</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>16</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from <u>4-24</u> , 19 <u>82</u> , to <u>5-4</u> , 19 <u>82</u> , that (II) (we) lost saw the deceased alive on <u>5-4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Kevin A. Peterson MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5-4-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin A. Peterson MD				22e. ADDRESS Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5/6/82		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.					
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR MAY 6 1982						25b. REGISTRAR'S SIGNATURE <u>Frances Jan. Nathan</u>	

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1000 York Road, Elton, N.Y. 11511
Henry W. Johnson & Co.
Credit for

Ref. in relation to

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										3	2	1	1	8	2	6	
1 - FOR STATE REGISTRAR										REG. NO:							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT S. BLOODSWORTH										2a. DATE OF DEATH MONTH DAY YEAR May 18, 82				2b. HOUR 6:20 PM			
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-27-20			6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Eastern Stairless							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.										13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6 Joppawood Ct. -21236	
14. FATHER'S NAME FIRST MIDDLE LAST Hubert Bloodsworth					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie V. Courtney												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 00011		17. INFORMANT Mrs. Marie M. Bloodsworth			ADDRESS 6 Joppawood Ct. Perry Hall, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) METASTATIC PROSTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from May 17, 1982 to May 18, 1982 , that (I) (we) last saw the deceased alive on May 18, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, I did not see the body after death.)																	
22b. SIGNATURE <i>David Bosia</i> DEGREE MD										22c. DATE SIGNED 5-18-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID BOSIA MD.										22e. ADDRESS CURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO. MD. 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-21-82		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.									
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS										25a. DATE RECD. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Miller</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 1

1. DECEASED NAME (TYPE OR PRINT) 1 (EARLENE) F. Bloom		2a. DATE OF DEATH MONTH DAY YEAR 5 20 82		2b. HOUR 5:55 P.M.
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 12 19 22	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Willie Roy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Braxton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. N/A	17. INFORMANT James Roy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RENAL FAILURE				
19a. DATE OF OPERATION 5/19	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BOWEL OBSTRUCTION	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/19 19 82, to 5/20 19 82, that (I) (we) lost saw the deceased alive on 5/20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Dean Kane MD	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 5/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEAN KANE MD	22e. ADDRESS SINAI HOSP OF BALTO			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/26/82	23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc.		25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]
ADDRESS 1101 E. North Ave.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 8 2 8			
1 - STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST George NMI - BLUE				MONTH DAY YEAR MAY 8 1982				01:10 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. YEARS		8. UNDER 1 YEAR	
M		B		MONTH DAY YEAR 12 31 23		58				IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				CITY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CITY		University of MD Hosp									
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD				BALZ CITY		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>		734 W. FAYETTE ST	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Eugene BLUE				FIRST MIDDLE LAST Florence HAYES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMATION		ADDRESS			
7				214 18 24M		Helen Blue		734 W. Fayette St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) VENTRICULAR ARRHYTHMIA										<10 min	
1619 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										<10 min	
(b) Intrabronchial Hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF											
(c) CA of LARYNX AND ESOPHAGUS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
4/2 5/7				CA of esoph, Rest ARREST				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 4/2 1982 to 5/7 1982, that (1) we last saw the deceased alive on 4/2 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Scott Kurteman				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				5/8/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Scott Kurteman				Univ. of MD Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Burial				5/14/82		Cedar Hill Cem..		Anne Arundel Co.		MD	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H, Inc. 1101 E. North Ave.						MAY 11 1982		Charles J. Harkin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 8 2 9	
FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
Benjamin W. Blum				5-19-82	
3. SEX		4. RACE		5. DATE OF BIRTH	
MALE		white		MONTH DAY YEAR	
				7 2 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MARYLAND		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
				BALTO CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. US. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balto		Union Memorial		12b. KIND OF BUSINESS OR INDUSTRY	
				SHIPPING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STREET ADDRESS	
13a. STATE MARYLAND 13b. COUNTY BALTIMORE				APT. 924	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
MOSES BLUM				FANNIE HERZFELD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		216-10-6024		SAM D. BLUM ADDRESS	
				3935 CLOVERHILL RD. BALTO., MD 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) Acute Myocardial Infarction					
4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 5-19-19 82 that (I) last saw the deceased alive on 5-17-19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body at death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
M. Main L. Cohen MD		MD		5-19-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
M. Main L. Cohen MD		201 E. University Pkwy - 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MAY 21, 1982		BETH TFILOH	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., INC.		MAY 25 1982		Frances Jan Nathan	
6010 REISTERSTOWN RD. BALTO., MD 21215					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8-2 11830 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Anna Louise Bodfish					2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
3. SEX Female					4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.					7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto., Md.					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.					13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Marcellus E. McDowell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna L. Kaiser						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-48-1080		17. INFORMANT ADDRESS Mr. Read McCaffrey, Balto., Md.				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRAIN METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rectal Carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mins</u> <u>3 months</u> <u>12 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>MALE NUTRITION - DIABETES - EXCISION RECTAL CANCER COLOSTOMY</u>											
19a. DATE OF OPERATION <u>2-13-82</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rectal Mass</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-04</u> 19 <u>76</u> to <u>5-18</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5-18-82</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death											
22b. SIGNATURE <u>[Signature]</u>						DEGREE		22c. DATE SIGNED <u>5-18-1982</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WOS ZEBLEY MD</u>						22e. ADDRESS <u>700 W 40th Street 21211</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE <u>5/19/82</u>		23c. NAME OF CEMETERY OR CREMATORY Green Mount			23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212						25. DATE REC'D. BY REGISTRAR MAY 20 1982 REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 1 8 3 1			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernhard D. Bohn										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5 2 1982		2b. HOUR M 6:24 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1904		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 77		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 2 1982			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Furniture			
13a. STATE Maryland			13b. COUNTY - - -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 255 S. Ann St.				
14. FATHER'S NAME FIRST MIDDLE LAST John - Bohn					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie - Simon								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - -		17. INFORMANT Minna Bohn			ADDRESS 255 S. Ann St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>			M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 5-3-82				
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 6, 1982		23c. NAME OF CEMETERY OR CREMATORY OakLawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE - - Baltimore Co. Md					
24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.						25a. DATE REC'D. BY REGISTRAR MAY 3 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Smith</i>					

11111

NOTICE TO THE PUBLIC

James D. ...

Sept. 10, 1911

X

United States

Various

Truck Driver

X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2835.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 3 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nollie Boice			2a. DATE OF DEATH MONTH DAY YEAR May 8, 1982		2b. HOUR 8:20 A.M.				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 24 23		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William F. Boice			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flonnie Walls						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-42-0315		17. INFORMANT Mary E. Boice			ADDRESS 2615 W. Fayette St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the Prostate 1850 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Severe Anemia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 2, 1982 to May 8, 1982 that (I) (we) lost xx above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hisham Bassiouny, M.D.					DEGREE M.D.		22c. DATE SIGNED 5/8/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hisham Bassiouny, M.D.					22e. ADDRESS c/o Maryland General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/13/82		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD		
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.					25a. DATE REC'D. BY REGISTRAR MAY 11 1982				
					25b. REGISTRAR'S SIGNATURE Charles J. Nathan				

MEDICAL CERTIFICATION

82 11832

May 11, 1952

Police

Police

Baltimore City

Baltimore General Hospital

Baltimore

Scientific Corporation of the President

Severe Weather



May 11, 1952

May 11, 1952

May 11, 1952

City of Baltimore General Hospital

City of Baltimore General Hospital

May 11, 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 1 1 8 3 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FRANK . BOLEK					2a. DATE OF DEATH MONTH DAY YEAR MAY 24, 1982				
3. SEX M					2b. HOUR 3:30 PM				
4. RACE W					6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS				
5. DATE OF BIRTH MONTH DAY YEAR 1-1-1912					8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 74 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND					9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY - MD.				
7b. CITIZEN OF WHAT COUNTRY? U.S.A.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WELDER				
10. CITY OR TOWN OF DEATH BALTO.					12b. KIND OF BUSINESS OR INDUSTRY KOPPERS Co.				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY MD. ALAN ARUNDEL					13b. STREET ADDRESS 226 MAPLE AVE.				
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BOLEK					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES UHLIK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 215-09-5852				
17. INFORMANT ADDRESS Mrs. Helen M. Bolek - 3009 Erdman Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse. 1519 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Septic (c) post-op → unresolvable stomach CA PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 5/12, 19 82, to 5/24, 19 82, that (I) (we) last saw the deceased alive on 5/24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death, so state.)									
22b. SIGNATURE DEGREE Paul Karpis MD									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION									
23b. DATE 5-26-82									
23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEM.									
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.									
24. FUNERAL DIRECTOR NAME ADDRESS Fantele Miller - 7527 Harford Rd.									
25a. DATE REC'D. BY REGISTRAR MAY 26 1982									
25b. REGISTRAR'S SIGNATURE Renee J. [Signature]									

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 8 3 4 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
FIRST MIDDLE LAST Sidney I. Booker				2a. DATE OF DEATH MONTH DAY YEAR May 30, 1982			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 8 08		6. AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2210 Allendale Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Majett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-18-5182		17. INFORMANT ADDRESS James N. Booker 2210 Allendale Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm, multiple, recent 6 wks. 4349 DUE TO, OR AS A CONSEQUENCE OF: (b) hypertension 5 yrs. (c) AS DUE TO, OR AS A CONSEQUENCE OF: - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/8 19 77 , to 5/30 19 82 , that (I) (we) lost saw the deceased alive on 5/19/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wm. C. March				DEGREE MD		22c. DATE SIGNED 6-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 600 Reisterstown Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				25a. DATE REC'D. BY REGISTRAR JUN 3 1982			
ADDRESS 1101 E. North Ave.				25b. REGISTRAR'S SIGNATURE James N. Booker			

8-11-58

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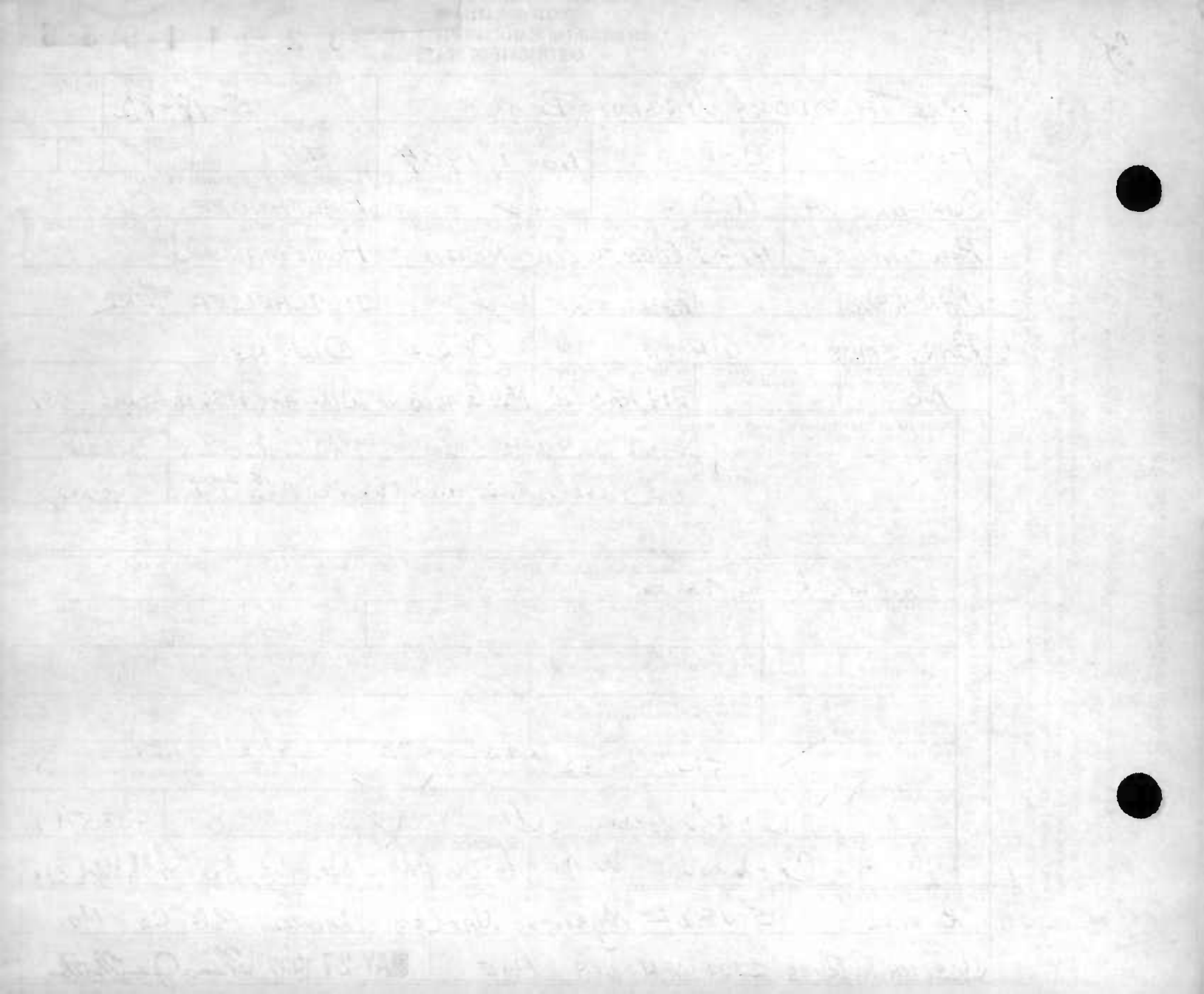
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 1 1 8 3 5				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MRS THEODORA VIRGINIA BOONE					2a. DATE OF DEATH MONTH DAY YEAR 5-18-82				
3 SEX FEMALE		4 RACE COL		5. DATE OF BIRTH MONTH DAY YEAR NOV 1, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SUFFOLK VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4132 WESTVIEW ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS 2167 CHELSEA TERR		
14. FATHER'S NAME FIRST MIDDLE LAST BARTHEMUS WHITE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA OWENS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219 16 5220		17. INFORMANT ADDRESS MRS GEARLDINE WILLIAMS 1136 N. LOMBARD ST					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Obstructive and Restrictive Pulmonary Disease 1370 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Old Tuberculosis and Chronic Bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Arrhythmia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/14/82 to 5/18/82 , that (I) (we) last saw the deceased alive on 5/14/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. A. Cochran				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. A. Cochran				22e. ADDRESS 6506 PARK HEIGHTS AVE BALTIMORE 21211					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-25-82		23c. NAME OF CEMETERY OR CREMATORY MARYLAND NAT CEM		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P.G. Co MD			
24. FUNERAL DIRECTOR NAME JOSEPH H. RUSS				ADDRESS 2122 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR MAY 27 1982		25b. REGISTRAR'S SIGNATURE Rhine J. Norton	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 8 3 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FRANKLIN - BOOZ				2a. DATE OF DEATH MONTH DAY YEAR 05-11-82			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 1 1 06		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Allen F. Booz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 911-22-4476		17 INFORMANT ADDRESS Mr. Allen Booz 615 Aster St. Norristown, Pa.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 82 , to 5/11 , 19 82 , that (I) (we) lost saw the deceased alive on 5/11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Duncan Salmon MD				22c. DATE SIGNED 5/11/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DUNCAN SALMON	
22e. ADDRESS 3100 WYMAN PARK DR. BALT MD 21211							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5/14/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR MAY 21 1982			
ADDRESS Balto., Md.				25b. REGISTRAR'S SIGNATURE Frances Jean Nathan			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 1 8 3 7	
FOR 1- STATE REGISTRAR			CERTIFICATE OF DEATH				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Catherine Booze						2a. DATE OF DEATH MONTH DAY YEAR 5/28/82			2b. HOUR 9 ⁴⁰ P.M.		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH 7 TH 22 ^{AY} 19		6. AGE (IN YEARS LAST BIRTHDAY) 62		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? US		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE						13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 874 BETHUNE ROAD			
14. FATHER'S NAME GEORGE MIDDLE JONES				15. MOTHER'S MAIDEN NAME BERTHA MIDDLE JONES LAST JONES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT DONALD BOOZE				ADDRESS 1426 LIMIT AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 1809 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Metastatic Epidermoid CA of Cervix</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/18/1982</u> to <u>5/28/1982</u> , that (I) (we) lost saw the deceased alive on <u>5/28/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE <u>Marcella L Roenneburg, MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <u>5/28/82</u>			
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Marcella L Roenneburg, MD</u>								22d. ADDRESS <u>Union Memorial Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 6-3-82		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS ADDRESS 1721 N. MONROE ST.						25a. DATE REC'D. BY REGISTRAR JUN 2 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 8 3 8	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORRIS BORENSTEIN						2a. DATE OF DEATH MONTH DAY YEAR SUNDAY, MAY 2, 1982		2b. HOUR 1:10 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 28, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3912 CLARINTH RD. (21215)				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. STATE MARYLAND						13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE			
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL BORENSTEIN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE SABOTA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215-24-1840A		17. INFORMANT ADDRESS MRS. JACOB SHULMAN 3912 CLARINTH RD. (21215)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAL FAILURE 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CONGESTIVE CARDIOMYOPATHY (c) 5 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one yr.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 28 AM 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —							
22a. I certify that (I) (this hospital) attended the deceased from Aug 17 19 82 to 2 MAY 82 , that (I) (we) last saw the deceased alive on 28 AM 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If two or more did not view the body after death.)											
22b. SIGNATURE Malcolm S. Oroszlan MD						22c. DATE SIGNED 5-3-82		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) PETER OROSZLAN						22f. ADDRESS 600 REISTERSTOWN RD. (21208)					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 5-3-82		23c. NAME OF CEMETERY OR CREMATORY WORKMANS CIRCLE		23d. LOCATION CITY COUNTY STATE BALTIMORE, MD.					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERS TOWN RD. BALTIMORE, MD (21215)						25a. DATE REC'D. BY REGISTRAR MAY 4 1982		25b. REGISTRAR'S SIGNATURE Charles J. Nathan			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 8 3 9 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) John A. Bosse				2a. DATE OF DEATH MONTH DAY YEAR May 9, 1982			
3 SEX Male				4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 29, 1906	
6 AGE (IN YEARS LAST BIRTHDAY) 75 yrs		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3335 Beech Avenue		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		15. KIND OF BUSINESS OR INDUSTRY --	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Bosse		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Krause		16. STREET ADDRESS 3335 Beech Avenue (21211)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) --		17 INFORMANT ADDRESS Mrs. Lottie A. Bosse- 3335 Beech Ave. 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Arrhythmia</u> 4241 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aortic Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minute</u> <u>10yr</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/8/82</u> 19 <u>81</u> to <u>5/2/82</u> 19 <u>82</u> , (or (I) (we) lost view the deceased alive on <u>5/2/82</u> above, (I) (we) (did) (did not) view the body after death) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <u>Richard L. Diamond</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-10-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard L. Diamond, M.D.				22e. ADDRESS 3547 Chestnut Ave., Balto., Md. 21211			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/12/82		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME A. Alan Seitz Funeral Home				ADDRESS 3818 Roland Ave.		25a. DATE REC'D. BY REGISTRAR MAY 13 1982	
				25b. REGISTRAR'S SIGNATURE <u>Frances Jean Wither</u>			

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Handwritten signature or name, possibly "Robert A. [unclear]".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 4 0

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST JOSEPH M. BOTTS		2a. DATE OF DEATH MONTH DAY YEAR MAY 22, 1982		2b. HOUR 12:53a	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 24 10		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1805 E. North Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST William Botts				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-03-7286		17. INFORMANT ADDRESS Armentia J. Botts 1805 E. North Avenue					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u></p> <p>4100 DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b) <u>myocardial infarction</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>metastatic cancer of colon</u></p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> , 19 <u>82</u> , to <u>5/22 0033</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/22 0033</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Keith T Swertson, MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEITH T SWERTSON, MD				22e. ADDRESS JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/26/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore		23e. DATE REC'D. BY REGISTRAR MAY 24 1982	
24. FUNERAL DIRECTOR Wm. C. March F/H 1101 E. North Ave.				25. DATE REC'D. BY REGISTRAR MAY 24 1982					

24. FUNERAL DIRECTOR

Wm. C. March F/H 1101 E. North Ave.

25. DATE REC'D. BY REGISTRAR

MAY 24 1982

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Woodrow Bowden						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 5 9 1982		2b. HOUR M 10:22 a M			
1. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 12 12	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 9 1982		2d. HOUR a M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2425 Arunah Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2425 Arunah Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Major Bowden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Paige							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-50-7401		17. INFORMANT Venetta Kelly		ADDRESS 2425 Arunah Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				TITLE (SPECIFY) M.D. Deputy Chief		MEDICAL EXAMINER		DATE SIGNED 5/11/82			
ACTUAL SIGNATURE <i>Thomas D. Smith</i>											
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/14/82		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc.				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 14 1982					
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 8 4 2	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) HENRY BOWLES					2a. DATE OF DEATH MONTH DAY YEAR 05-12-82			2b. HOUR 2:00pm			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 5 01		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Wesley Bowles					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marlie Green						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 705-12-4013		17. INFORMANT ADDRESS Myrtle Bowles 1629 N. Milton Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE LEFT CEREBRAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRONCHITIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 05-04-82				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FEEDING GASTROSTOMY TUBE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 05-12-82 to 05-12-82 , that (I) (we) last saw the deceased alive on 05-12-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE J. Kawaja				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5.12.82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. J. KAWAJA M.D.				22e. ADDRESS CHURCH & HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 31							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/18/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY MD Baltimore Co. MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 17 1982 Thomas J. Thorton			

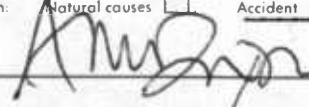
ST 011-28

EX-1104-1154



ST 011-28

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11843	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CRAIG ANTHONY BOWMAN										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 2 1982	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 1 57		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 25	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 2 1982		2b. HOUR 11:45 a.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2416 Loyola Northway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2414 Loyola Southway			
14. FATHER'S NAME FIRST MIDDLE LAST Cleve Bowman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Holcomb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 214-68-3878		17. INFORMANT ADDRESS Gladys Powell 1641 N. Bentalou St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral injury complicating acute</u> DUE TO, OR AS A CONSEQUENCE OF <u>alcoholism</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30xx 5-2- 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell from balcony.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bldg.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2416 Loyola Northway, Balto. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 5-3-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR MAY 4 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME		2a. DATE OF DEATH		2b. HOUR	
FIRST	MIDDLE	MONTH	DAY	YEAR	
MARY ANNA BOWMAN		5-18-82		9:15p	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F	W	11/ 10/ '15		66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Balto.		St. Agnes Hosp.		Ret/Aide	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Md.		Howard		4644 Woodland Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John Barth		Lilly Porter Barth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		217-07-6500		Mr. Willia, Bowman 4644 Woodland RD 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: 4230 IMMEDIATE CAUSE (a) ARRYTHMIA with hemopericardium 400. min.					
DOE TO, OR AS A CONSEQUENCE OF (b) PROBABLE Sarcoid Cardiac catheterization					
DOE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Sarcoidosis with myocardial involvement.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27a. SIGNATURE		DEGREE		27b. DATE SIGNED	
Michael E. Pelczar		MD		5/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Michael E. Pelczar, M.D.		900 Caton Ave. St. Agnes Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		May 22, 1982		Crest Lawn	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harry H Witzke 4112 Columbia Rd Ellicott City		MAY 24 1982		[Signature]	
23d. LOCATION CITY OR TOWN		23e. COUNTY			
Howard Maryland					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 4 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDITH BOWSER			2a. DATE OF DEATH MONTH DAY YEAR 4-30-82			2b. HOUR 4:02 p.m.			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 14 1893		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) US		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE BALTO.		13b. COUNTY		13c. CITY OR TOWN CITY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2525 W. Belvedere Ave	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 215-32-1149		17. INFORMANT CHART ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 4810 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ① Lobe Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ASCND, CVA + angiotensin diatriene									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/30 , 19 82 , to 4-30 , 19 82 , that (I) (we) last saw the deceased alive on 4/30/ 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ebenezer					DEGREE MBBS ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHEILA EBENEZER					22e. ADDRESS SINAI HOSPITAL, BALTO. MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/5/82		23c. NAME OF CEMETERY OR CREMATORY ASbury Ch-Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Abbury HA MD		
24. FUNERAL DIRECTOR NAME GEORGE W TITTLE ADDRESS BELAIR MD					25a. DATE REC'D. BY REGISTRAR MAY 21 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>		

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RECEIVED

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RECEIVED

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH NOTICES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		Item 22a Film 570 8-13-82 cn		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				2 1 1 8 4 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST LESLIE W. BOWSER				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-27-82	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 7 59		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-27-82 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4313 Maine Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4313 Maine Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Bowser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carol Harrell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Edward Bowser 4313 Maine Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of back with complications</u> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-27-82 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) unknown		21f. LOCATION STREET CITY OR TOWN STATE Baltimore, Maryland			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Morgue Dr. Thel				TITLE (SPECIFY) M.D.				DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/82		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 3 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 8 4 7 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jr. (BOYD) Charlie (CHARLES) Boyd				5 20 82				M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAFAYETTE SQUARE NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3800 W. Belvedere Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Boyd Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Jenkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 216-09-5574		17. INFORMANT ADDRESS Willie E. Boyd 4807 Kimberleigh Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 VENTRICULAR ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (b) ASD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE Many years								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CVA	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-12-82, to 5-20-82, that (I) (we) lost saw the deceased alive on 5-20-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Shtaukat Y. Khan				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-21-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHTAUKAT Y. KHAN				22e. ADDRESS 1528 King William Drive, Balt MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/25/82		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l mem Ph.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAY 24 1982 Thomas J. ...			

at
1000



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 1 8 4 8
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>ELEANORA E. Boyd</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-3-82</i>			2b. HOUR <i>3:15 P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>Col</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>APR. 19, 1920</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN) <i>BALTO. MD.</i>		9. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
12. CITY OR TOWN OF DEATH <i>BALTO.</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SPEC. FACILITY, GIVE STREET ADDRESS) <i>3902 Montwood Rd.</i>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <i>Maryland BALTO.</i>					17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS <i>3902 Montwood Rd</i>		
19. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Brooks</i>			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELEANORA Blanton</i>						
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			22. SOCIAL SECURITY NO.			23. INFORMANT ADDRESS <i>Mrs. Charles Brooks 3902 Montwood Rd</i>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Small Cell Lung Cancer*
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>81</i> , to <i>May</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>April</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>P. K. R. R.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/4/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. K. R. R.</i>				22e. ADDRESS <i>Lutheran Hospital 730 Ashblinton St</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-7-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maryland Nat'l Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. Co. Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Joseph L. Russ 2222 W. North Ave</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAY 10 1982 J. K. R. R.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 1 8 4 9			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Shirley Boyd						2a. DATE OF DEATH MONTH DAY YEAR 5/19/82				2b. HOUR 2:30 AM			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 01/10/20		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1806 Dukeland ST.					
14. FATHER'S NAME FIRST MIDDLE LAST Henry Boyd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Moore									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 230-34-4820		17. INFORMANT Carrie Boyd		ADDRESS 1806 Dukeland St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 Cardiac Arrest IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (if this hospital) attended the deceased from 05-04 , 19 82 , to 05-05 , 19 82 that (if we) lost saw the deceased alive on 05/05/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.													
22b. SIGNATURE Sissat Awok						DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 05/09/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SISSAT Awok						22e. ADDRESS Lutheran Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/15/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc.						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 14 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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WILSON

Item 7a 8567 7/10/82 g3

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <i>Zephia Boyd</i>		2a. DATE OF DEATH		MONTH DAY YEAR <i>5 1 82</i>		2b. HOUR <i>6:27 PM</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 23 85</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>97</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>97</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>UNKNOWN</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE - City</i> MD.			
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>LUTHERAN HOSPITAL</i>		12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MO</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1501 N DUKELAND ST</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>218-540254</i>		17. INFORMANT ADDRESS <i>Mrs. Edell Marcus 1501 Duke Land St</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> <i>0389</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>CVA</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>04-26</i> , 19 <i>82</i> , to <i>5-1</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>5/1/82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>S. S. 89 Anthe</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/1/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. S. 89 Anthe</i>		22e. ADDRESS <i>Lutheran Hospital</i>							
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i>		23b. DATE <i>5-6-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Lansdowne Gnt</i>			
24. FUNERAL DIRECTOR NAME <i>Joseph L. Russ</i>		ADDRESS <i>2222 W. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 4 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY OF THE FOLLOWING ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11852	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		26. HOUR	
Alicia						Brown		XX MONTH DAY YEAR		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		26. HOUR	
Female	Black	9 3 580		1 YRS.		MONTHS DAYS		HOURS MIN.		5:15 a.m.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Baltimore		U.S.A.		WIDOWED		DIVORCED		Baltimore City,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		4147 Park Heights Avenue		None		None					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD				Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		4147 Park Hgts Ave.			
14. FATHER'S NAME		15. MOTHER'S M maiden name		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Harry		None				32341		Baltimore St 21123			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES?		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
None		None				32341		Baltimore St 21123			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a): Smoke Inhalation											
8902											
DUE TO, OR AS A CONSEQUENCE OF											
(b):											
DUE TO, OR AS A CONSEQUENCE OF											
(c):											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				4:15 PM 5 18 82				subject in housefire			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				Home				4147 Park Heights Ave., Baltimore, Md.			
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Virginia L. Dolan				Assistant				5-18-82			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Virginia L. Dolan, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				5 25 82				Catholic			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Alitha				MAY 21 1982				Ruth J. North			

BP

11021

11021



Handwritten notes and diagrams, including a large 'X' shape and various scribbles.

Handwritten notes at the bottom of the page, including the word 'Electric'.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages head 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 8 5 3			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Joseph T Brandt				5 18 82				10p M			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 HRS	
Male		White		MONTH 7 DAY 15 YEAR 29		52 YRS		10 MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		ST AGNES HOSPITAL				Pool room operator					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1238 Ten Oaks Road			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Paul A. Brandt				Evelyn Ambrose							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		130/48-2151		220-24-8403		Mrs. Charlotte L. Brandt 1238 Ten Oaks Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic liver disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Small Cell Carcinoma of lung with liver metastasis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Superior Vena Cava Syndrome</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5-18</u> 19 <u>82</u> , to <u>5-18</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5-18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lawrence Zeidman</u>				DEGREE MD				22c. DATE SIGNED 5/18/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lawrence Zeidman</u>				22e. ADDRESS 900 CATON AVE BALTIMORE MD 21229							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE 5/22/82		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Howard Md.</u>					
24 FUNERAL DIRECTOR NAME <u>Ambrose Funeral Home, Inc.</u>				ADDRESS <u>1328 Sulphur Spring</u>		25a. DATE REC'D. BY REGISTRAR MAY 20 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>			

11330

Joseph T. Standt

BALTIMORE CITY

BALTIMORE ST AGNES HOSPITAL

Admission Record

20th Ward Case

X

100 CATON AVE BALTIMORE MD 21229



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

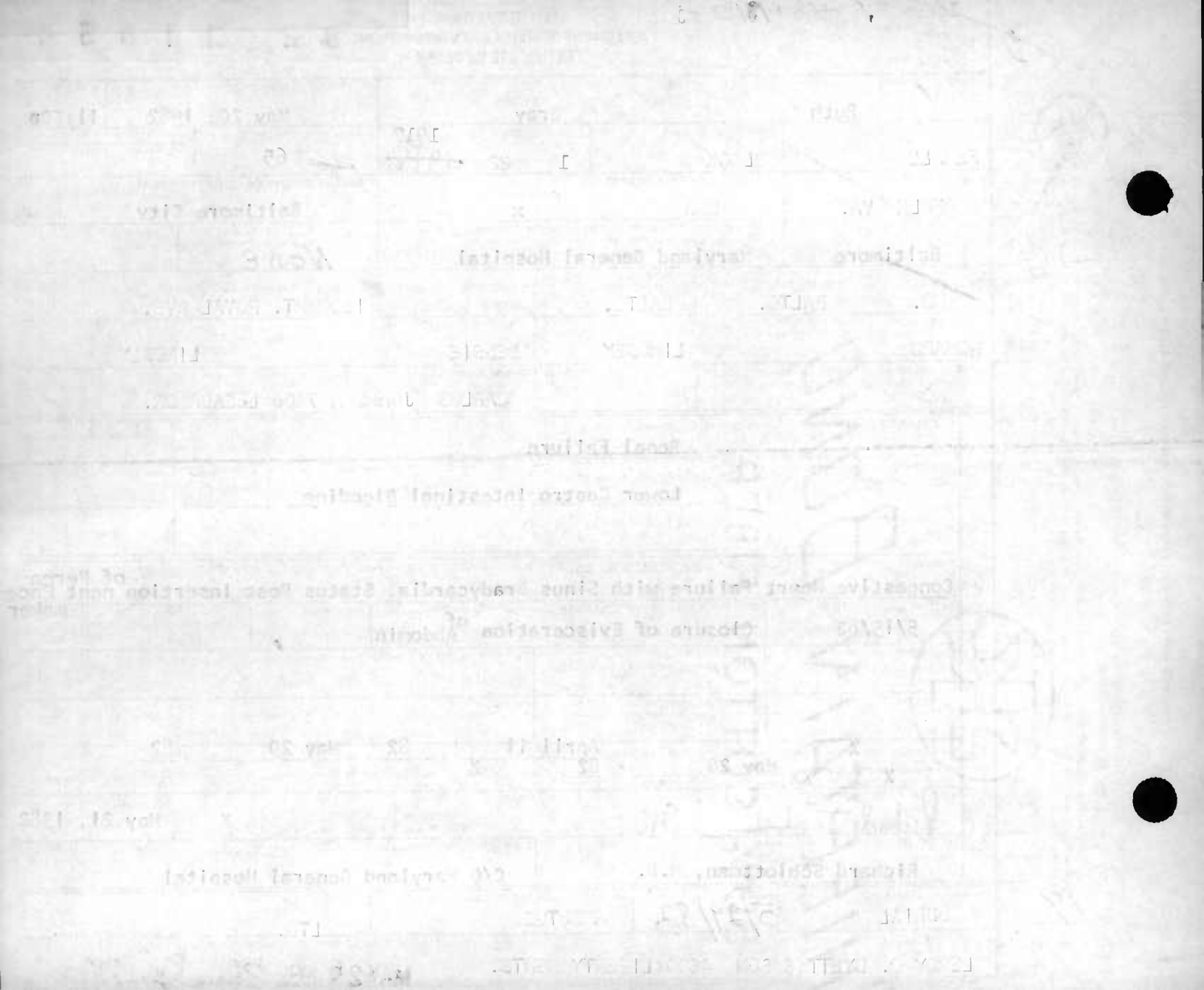
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 3, 6 g568 6/8/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Bray			2a. DATE OF DEATH MONTH DAY YEAR May 20, 1982			2b. HOUR 11:50 PM			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 22 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORFOLK VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD LINDSEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE LINDSEY			13e. STREET ADDRESS 1600 MT. ROYAL AVE.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CARLOS JOHNSON 7406 LESADA DR.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Lower Gastro-Intestinal Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Congestive Heart Failure with Sinus Bradycardia, Status Post Insertion of Permanent Pacemaker									
19a. DATE OF OPERATION 5/15/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Closure of Evisceration of Abdomen			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 11 1982 to May 20 1982 , that (I) (we) last saw the deceased alive on May 20 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Richard Schlottman MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED May 21, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Schlottman, M.D.						22e. ADDRESS C/O Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/29/82		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT & SON 4600 LIBERTY HIGHTS.						25a. DATE REC'D. BY REGISTRAR MAY 26 1982		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



1. DECEASED NAME (TYPE OR PRINT) Rosetta Brand		2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 5 18 1982		2b. HOUR M 5:15 a. M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 9 71	6. AGE (IN YEARS LAST BIRTHDAY) 11 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 18 1982
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4147 Park Heights Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None
13a. STATE Md		13b. COUNTY Ct		13c. CITY OR TOWN Baltimore
14. FATHER'S NAME FIRST MIDDLE LAST Harry Brand		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST None		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. Unknown		17. INFORMATION ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke Inhalation DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: 8902				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:15 PM 5 18 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in housefire
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4147 Park Heights Ave., Baltimore, Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Virginia L Dolan		TITLE (SPECIFY) Assistant		DATE SIGNED 5-18-82
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-25-82	23c. NAME OF CEMETERY OR CREMATORY Arbiter Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md
24. FUNERAL DIRECTOR NAME William L. Liggins		ADDRESS 3207 W. 7th Ave		25a. DATE REC'D. BY REGISTRAR MAY 21 1982
				25b. REGISTRAR'S SIGNATURE None

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1152

RECEIVED



LIBRARY

Handwritten notes and signatures, including the word "Library" and various illegible scribbles.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 1 8 5 6
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FLORENCE U. BRETT			2a. DATE OF DEATH MONTH DAY YEAR MAY 3, 1982		2b. HOUR 1:15a		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 15 1909		6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. Co.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur G. Ueberroth, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche E. Scholl		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-50-2212	
17. INFORMANT Arthur G. Ueberroth, Jr.		17. ADDRESS 21403 Georgetown Rd. Unit #2-Annap., MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4151 DUE TO, OR AS A CONSEQUENCE OF (b) Staphylococcus Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Emboli		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diverticulitis with bowel perforation							
19a. DATE OF OPERATION 5/3		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diverticulitis with bowel perforation		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/3 , 19 82 , to 5/3 , 19 82 , that (I) (we) lost saw the deceased alive on 5/3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Mitchell Gilbert MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Mitchell Gilbert MD		22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/6/1982		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR MAY 5 1982		25b. REGISTRAR'S SIGNATURE Theresa Ann Wether	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper (if any) and file it in your files. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

DHMH - 16 60M 1/75
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 8 5 7			
FOR 1- STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) THOMAS G. BREWER					2a. DATE OF DEATH MONTH DAY YEAR 5 17 82					2b. HOUR 3:30 AM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 5 21		6. AGE (IN YEARS LAST BIRTHDAY) 60		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		8. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2433 W. North Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST Mack Brewer Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Davis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes					16b. SOCIAL SECURITY NO. 246-18-0132		17. INFORMANT ADDRESS Rosa Leen Brewer 2433 W. North Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 4360 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from APRIL 29, 19 82 to MAY 17, 19 82 , that (I) (we) last saw the deceased alive on MAY 17, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE J. M. Jumanoy, M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. M. JUMANOY, M.D.						22e. ADDRESS PROVIDENT HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/22/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR MAY 19 1982		25b. REGISTRAR'S SIGNATURE Rosa Leen Brewer					

MEDICAL CERTIFICATION

12611 28

500 01 YAN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE Bridgett		LAST Bridgett		2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 22 23		6. AGE IN YEARS (LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 5 18 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2406 Edmondson Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2406 Edmondson Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST John Bridgett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Carraway		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes		16b. SOCIAL SECURITY NO. 217-12-6298		17. INFORMANT Beatrice Horne		ADDRESS 3425 Dolfield Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of dissecting aortic aneurysm</u> 4410 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 5/19/82					
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Balto. MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/25/82		23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cemetery		23d. LOCATION CITY OR TOWN Crownsville		COUNTY MD		STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc.		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

00011 20

THE UNIVERSITY OF CHICAGO
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

DHMH-16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 1 8 5 9	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATIE E BRIGHTWELL						2a. DATE OF DEATH MONTH DAY YEAR 5 4 1982		2b. HOUR 10 A		M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 21 06		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS 76		IF UNDER 24 HRS. HOURS MIN. 10 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.					
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE MD		13b. COUNTY CHARLES		13c. CITY OR TOWN BENEDICT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 143			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM FOWLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE BEVERLY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-16-1172		17. INFORMANT Elizabeth Maffett				ADDRESS Scmco #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) TACHYCARDIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 4 d.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ---											
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 4/18 , 19 82 , to 5/4 , 19 82 , that (I) lost saw the deceased alive on 5/4 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) will (did) not view the body after death.											
22b. SIGNATURE Edward J. Lee				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/4/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD J. LEE				22e. ADDRESS 22 S. GREENE ST, BALTO, MD, 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-7-82		23c. NAME OF CEMETERY OR CREMATORY St Pauls		23d. LOCATION CITY OR TOWN COUNTY STATE Prince Frederick, Calvert Md					
24. FUNERAL DIRECTOR NAME Kausch Funeral Home, Owings md				ADDRESS Box 45A		25a. DATE REC'D. BY REGISTRAR MAY 13 1982		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 1 8 6 0	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LACY PAUL BRITT					2a. DATE OF DEATH MONTH DAY YEAR 5 25 82			2b. HOUR 10¹⁰ PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 29 17		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WELDER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN LANSDOWNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2401 TIONESTA ROAD, 21227			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 240-16-2155		17. INFORMANT ADDRESS RITA E. BRITT 2401 TIONESTA ROAD, 21227							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest. 4402 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Generalized arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) Indefinite 5/25/82											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION 5/26/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Congruent ② for				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/11/82 to 5/25/82 , that (I) (we) last saw the deceased alive on 5/25/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE EFEM IMOKE, MD					DEGREE			22c. DATE SIGNED 05 25 82		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EFEM IMOKE, MD					22e. ADDRESS 900 CATON AVE BALTIMORE MD 21229						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 05-29-82		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.					25a. DATE REC'D. BY REGISTRAR MAY 28 1982		25b. REGISTRAR'S SIGNATURE James J. Thibodeau				

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

MAY 28 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 6 1

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
ALICE LOUISE BROOKS			MAY 14, 1982			8:10AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE	WHITE	3 - 2 - 1918	64 YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA	U.S.A.		BALTIMORE CITY			MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	CHURCH HOSPITAL, INC.		HOMEMAKER					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND	BALTIMORE	DUNDALK	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7006 MORNINGTON RD. 21222		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
EDWARD WILLIS MANUEL			SALLY HOFFMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			213.07.8426W			THELMA WEINHOLT 2908 DUNBRIN CT. 21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF KIDNEY</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 6</u> , 19 <u>82</u> , to <u>MAY 14</u> , 19 <u>82</u> , that (I/we) last saw the deceased alive on <u>MAY 14</u> , 19 <u>82</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we/we did) did not view the body after death.								
22b. SIGNATURE <u>A. J. Helou, M.D.</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>5/14/82</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. HELOU, M.D.			22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY, BALTIMORE, MD 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL			5/17/1982		BEL AIR MEMORIAL		BEL AIR HARBOR MD.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE RECD. BY REGISTRAR		
WALTER BROOKS BRADLEY, INC.			DUNDALK, MD. 21222			MAY 17 1982		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) Dorothy Brooks						2a. DATE OF DEATH MONTH 5 DAY 26 YEAR 82		2b. HOUR 6:15 PM	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH 3 DAY 5 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 67		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2126 S. Leadenhall St.	
14. FATHER'S NAME FIRST David MIDDLE Brooks LAST UNKNOWN						15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK.		16b. SOCIAL SECURITY NO. 215-05-8644		17. INFORMANT ADDRESS Myrtle Brooks 201 N Broadway					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of lung and lung abscess DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4d. 3 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic Obstructive Pulmonary Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from May 14 , 19 82 , to May 26 , 19 82 , that (1) (we) lost saw the deceased alive on May 26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.									
22b. SIGNATURE Jan Laws Houghton				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jan Laws Houghton				22e. ADDRESS 22 S. Greene St., Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-1-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN Baltimore COUNTY Baltimore STATE Md.			
24. FUNERAL DIRECTOR NAME Brown/ Thompson F.H. ADDRESS 1913 W. Balto. St.				25a. DATE REC'D. BY REGISTRAR JUN - 1 1982 25b. REGISTRAR'S SIGNATURE James J. Houghton					

Brown, Thomas W. H. 1913 W. B. 1914 - 1915
Mt. Auburn Co. - 1916
6-1-12

How many specimens of the same species
found in the same locality?

Green, C. (C. Green) 1913 W. B. 1914 - 1915
Mt. Auburn Co. - 1916

How many specimens of the same species
found in the same locality?

How many specimens of the same species
found in the same locality?

How many specimens of the same species
found in the same locality?

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) LILLIAN BROOKS					2a. DATE OF DEATH MONTH DAY YEAR 05 27 82 2b. HOUR A. M.					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 18 08		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 74		7. UNDER 1 YEAR MONTHS DAYS HOURS 0 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 56 OAKLEE VILLAGE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aide		12b. KIND OF BUSINESS OR INDUSTRY Baltimore County Bd. of Ed.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Campbell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 212-26-4658		17. INFORMANT ADDRESS William L. Einwaechter 20853 4520 Norbeck Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2500 <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) U3CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal Failure										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/22 19 82 to May 27 19 82 that (I) (we) last saw the deceased alive on 5/22 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John C. Healy</i>					22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 5/28/82		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. HEALY, M.D.					22f. ADDRESS 1311 FRANCIS AVENUE, 21227					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 05-29-82		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE PIKESVILLE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229					25a. DATE REC'D. BY REGISTRAR MAY 28 1982					
					25b. REGISTRAR'S SIGNATURE <i>James J. K... ..</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

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300

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 1 8 6 4			
FOR 1- STATE REGISTRAR				REG. NO.			
DECEASED NAME (TYPE OR PRINT) LOURINE W. BROOKS				20. DATE OF DEATH MONTH 5 DAY 8 YEAR 82 2b HOUR 8:10 P.M.			
3. SEX F		4. RACE Bl.		5. DATE OF BIRTH MONTH 5 DAY 30 YEAR 28		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL		12a. USUAL OCCUPATION (IF WORKING OR DOING OTHER WORKING LIFE) FOOD SERVICE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY				13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST WILLIAM MIDDLE WASHINGTON				15. MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE FORD LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 228-28-5758		17. INFORMANT NELLIE BRIGGS		ADDRESS 1637 MCKEAN AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO, OR AS A CONSEQUENCE OF (b) Asepsis DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of liver							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/8/82 to 5/8/82 that (I) (we) last saw the deceased alive on 5/8/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE P. Corbett				DEGREE		22c. DATE SIGNED 5-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PELADO E. CORREIA				22e. ADDRESS LUTHERAN HOSP. DR			
23a. BURIAL, CREMATION, REMOVAL REMOVAL		23b. DATE 5-9-82		23c. NAME OF CEMETERY OR CREMATORY DINWIDDIE MEMORIAL		23d. LOCATION CITY OR TOWN DINWIDDIE COUNTY VIRGINIA STATE	
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS ADDRESS 1721 N. MONROE ST.				25a. DATE REC'D. BY REGISTRAR MAY 10 1982 25b. REGISTRAR'S SIGNATURE James J. North			

BP

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be satisfied once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 8 6 5
REG. NO. | |
|--|--|--|--|---|-------------|---|--|--|----------------------|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Albert | MIDDLE
E | LAST
Brown, sr. | 2a. DATE OF DEATH
MONTH DAY YEAR
5 26 82 | | 2b. HOUR
11:55 AM | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 13 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 74 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BALTO CITY Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ship builder | | 12b. KIND OF BUSINESS OR INDUSTRY
Owens Yacht. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2000 Odell Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
H ubbard | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
H attie Corington | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
250-36-4960 | | 17. INFORMANT
Mrs. Rosalie Brown | | | | ADDRESS
2000 Odell Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiomyopathy arrest</u>
4254
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardiomyopathy</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes mellitus</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Isadore A. Feldman | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Isadore A. Feldman | | | | | | 22e. ADDRESS
Baltimore City Hosps. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE) | | 23b. DATE
6-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown Md. | | | | | |
| 24. FUNERAL DIRECTOR
JAS. A. MORTON & SONS | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 28 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Fisher | | | |
| ADDRESS
1701 LAURENS | | | | | | | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|--------------------------------|--|---|--|------|--|--|--|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| Antonio | | | | | | Brown | | X | | 5 | | 15 | | 1982 | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | | | |
| male | black | 6 18 74 | | 7 YRS. | | | | | | 5 | | 15 | | 1982 | | 1:45A | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Ga. | | USA | | | | Baltimore City | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | |
| Baltimore | | 2781 Tivoly Avenue | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2781 Tivoly Ave. | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Eddie Frazier | | | | Barbara Brown | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| N/A | | | | N/A | | | | Eloise Rice 1906 E. 31st St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Smoke and soot inhalation | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | 12:29 AM 5/15/82 | | | | housefire | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | home | | | | 2781 Tivoly Avenue, Baltimore City, MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | Assistant | | | | 5/15/82 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | | 5/22/82 | | | | Crestview Cem. | | | | Cairo, Ga. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Wm C March F/H | | | | 1101 E. North Ave. | | | | MAY 20 1982 | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 6 7

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Bertha L. Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 11, 1982 | | 2b. HOUR
5:30 P.M. | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
11 29 30 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
51 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS
1531 Montpelier St. | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Freddie Williams | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Dela L. Williams | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Palestina Brown 1531 Montpelier St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
1439
DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Carcinoma of Gum with Metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
Obesity
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 mos. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | |
| 19a. DATE OF OPERATION
3-10-1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Squamous Carcinoma of Gum (L) | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
<input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB , 19 82 , to MAY 11 , 19 82 , that (I) (we) last saw the deceased alive on MAY 11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Harold E. Ramsey, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-14-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD E. RAMSEY | | | | 22e. ADDRESS
301 McMECHEN ST. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Kistner |

WALL STREET JOURNAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 8 6 8 | | | |
|---|--|---|--|---|--|---|--|
| FOR
1. STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BESSIE S. BROWN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 5, 1982 | | 2b. HOUR
9:00AM | |
| 3. SEX
Female | | 4. RACE
Col. ✓ | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 28, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | |
| 7a. BIRTHPLACE
STATE OF FOREIGN
Country
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
6-S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | |
| 10. CITY OR TOWN OF DEATH
Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT SUCH FACILITY, GIVE STREET ADDRESS)
Church Home Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
Balt. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward D. Nickens | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mollie Craxton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
219-30-7624 | | 17. INFORMANT
Mr. Lawrence E. Nickens 5916 Old Frederick Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF STOMACH
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 13, 1982, to MAY 5, 1982, that (I) (we) lost
saw the deceased alive on MAY 5, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, and (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. R. Nazemi M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. NAZEMI, M.D. | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY, BALTIMORE, MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-10-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balt. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ 2222 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Van Thier | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 6 9

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) CLARA F. BROWN | | LAST | | 2a DATE OF DEATH
MONTH DAY YEAR
5-14-82 | | 2b HOUR
8 13 PM | |
| 3 SEX
FEMALE | | 4 RACE
Cauc. | | 5 DATE OF BIRTH
MONTH DAY YEAR
6 15 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY)
73 73 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Brookeville, Md. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hosp, Balto, Md. | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Saleslady | | 12b KIND OF BUSINESS OR INDUSTRY
Stewarts | |
| 13a STATE
Md | | 13b COUNTY
Balto. | | 13c CITY OR TOWN
Balto. | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Charles E. Cross | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith M. Phillips | | 13e STREET ADDRESS
3320 Willoughby Rd. 21234 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b SOCIAL SECURITY NO.
213-20-9775 | | 17. INFORMANT
Milton Brown, 4106 Gladden Ave. 21213 | | ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
4100
DUE TO, OR AS A CONSEQUENCE OF:
(b) Prob. ANTERIOR MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF:
(c) CORONARY ARTERY DISEASE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
DIABETES MELLITUS | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death | | | | | | | |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT)
ANTONIO S. RAYDA, MD | | 22c ADDRESS
GOOD SAMARITAN HOSP. | | 22d DATE SIGNED
5-14-82 | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
5/18/82 | | 23c NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24 FUNERAL HOME
Schlimmek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE
MAY 18 1982 | | | |

(M)

2

1

31

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Duke V. Brown | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
5 18 1982 | | | 2b. HOUR
M
5:15 a.m. | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12-21-1925 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
YRS.
6 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
5 18 1982 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balt. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4147 Park Heights Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Baby | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Duke Thomas A. Brown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sean Carol Moore | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
None | | | 17. INFORMANT
ADDRESS
Mr. Duke T. Brown 4015 KATHLAND AVE. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke Inhalation
8902
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4:15 p.m. 5 18 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject in housefire | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
4147 Park Heights Ave., Baltimore, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | | TITLE (SPECIFY)
M.D. Assistant | | | MEDICAL EXAMINER
DATE SIGNED 5-18-82 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5-25-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore City Md. | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ | | | ADDRESS
2222 W. North | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

✓
(M)

REELING BOARD

REELING BOARD
REELING BOARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director for 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 8 7 1 | | | |
|---|--|---|--|---|--|--|--|
| FOR
STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FRANCES LILLIAN BROWN | | | | MAY 13 1982 | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| F | | W | | MAY 27 1900 | | 84 82 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MICHIGAN | | U. S. A. | | | | BALTO. C.T. MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTO. | | 3318 GILMAN TERRACE | | Secy | | LAW OFFICE | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD | | | | | | BALTO | |
| 14. FATHER'S NAME
(FIRST MIDDLE LAST) | | | | 15. MOTHER'S MAIDEN NAME
(FIRST MIDDLE LAST) | | | |
| GORDON R. LANTZ | | | | FANNIE DUNHAM | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| NO | | 215-34-0052 | | Family | | Records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cecal Carcinoma
1534
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Hypertension | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1-21 19 70, to 5-12 19 82, that (I) (we) last saw the deceased alive on 5-11 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
William P. Benson, Jr. M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William P. Benson, Jr. | | | | 22e. ADDRESS
3506 Calvert St | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY | |
| BURIAL | | 5/15/82 | | Moreland Memorial | | BALTO. MD. | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| EVANS Funeral Chapel | | | | MAY 11 1982 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 8 7 2
REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Hezekiah Brown Jr. | | | | 20. DATE OF DEATH MONTH DAY YEAR
May 23, 1982 | | | |
| 2. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
9 4 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
827 Sheridan Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Hezekiah Brown Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Virginia Tyler | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
215-16-0838 | |
| 17. INFORMANT ADDRESS
Louise Brown 827 Sheridan Ave. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus
2500
DUE TO, OR AS A CONSEQUENCE OF (b) HCV D
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 yrs
3 yrs | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
2500 | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
091365 | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
052382 | |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21f. LOCATION CITY OR TOWN STREET COUNTY STATE
Baltimore City | | 21g. LOCATION CITY OR TOWN STREET COUNTY STATE
Baltimore City | | 21h. LOCATION CITY OR TOWN STREET COUNTY STATE
Baltimore City | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (myself) did not view the body after death. | | | | 22b. SIGNATURE
U. RAY JR. MD | | 22c. DATE SIGNED
052482 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
U. RAY JR. MD | | | | 22e. ADDRESS
2225 W. North Ave | | 22f. ADDRESS
21216 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore City MD | |
| 24. FUNERAL DIRECTOR (NAME)
Wm. C. March F/H | | | | 24b. ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1982 | |

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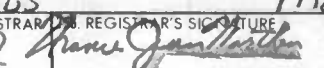
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 1 8 7 3 | |
|---|----------------------|--|---|---|--|--|--|---|--|------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James Brown | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 6 YEAR 1982 | | 2b. HOUR M | | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH
MONTH 01 DAY 28 YEAR 45 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 37 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD 5 6 1982 | | 2d. HOUR 11:15
P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2848 Round Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD. | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3211 GwynnsFalls Pkwy. | | | |
| 14. FATHER'S NAME
FIRST George MIDDLE R. LAST Brown | | | | 15. MOTHER'S MAIDEN NAME
FIRST Edith MIDDLE R. LAST Gresham | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. ? (lost) | | 17. INFORMANT ADDRESS Edith Brown 3211 GwynnsFalls Pkw | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9660 IMMEDIATE CAUSE (a) Stab wound of inguinal region
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR 11:10 P.M. MONTH 5 DAY 6 YEAR 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | | 21f. LOCATION
STREET 2848 Round Rd. CITY OR TOWN Balto. COUNTY STATE Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion, death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER | | | | DATE SIGNED 5/7/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-11-82 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS Mem. PK. | | 23d. LOCATION
CITY OR TOWN ARBUTUS COUNTY STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME Redd FUNERAL Home ADDRESS BALTO. MD. 5209 YOLK Rd. | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1982 REGISTRAR'S SIGNATURE  | | | | | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11874 | | |
|--|--|-------------------------|---|--|--|---|--|---|---|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James Edward Brown | | | | | | | | | | 2a. DATE OF DEATH
KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>
MONTH DAY YEAR 5 15 1982 | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR 10 28 51 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 30 | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 5 15 1982 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Fla. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)
2781 Tivoly Avenue | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1906 E. 31st St. | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lum Brown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Flossie McKinner | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS
Eloise Rice 1906 E. 31st St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke and soot inhalation
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:29AM 5/15 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
housefire | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2781 Tivoly Avenue, Baltimore City, MD | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie A. Korell | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED 5/15/82 | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street, Balto, MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestview Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cairo, Ga. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H | | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 5 2 1 1 8 7 5 | |
|--|------------------|---|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
JONATHAN Wright BROWN | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
5-30-82 19 | | | 2b. HOUR
M
8:45P | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 23, 1912 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
69 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
5-30-82 19 | 2d. HOUR
8:45P | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Lawyer - Agent | | 12b. KIND OF BUSINESS OR INDUSTRY
FBI | | | | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Anne Arundel Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2640 Shadow Cove, | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
E. Bernard Brown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lulu Wright | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT
ADDRESS
Jean C. Brown-wife- (same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>gunshot wound of head</u>
9554
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10:09Am 5-30-82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self/inflicted | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bedroom | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2640 Shadow Cove Annapolis, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED
5-31-82 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | ADDRESS
111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
June 3, 1982 | | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | 11800 N.H. Ave.,
Sil. Spring, Md. | | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1982 | | | 25b. REGISTRAR'S SIGNATURE
<i>James J. Nathan</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Randall Lee BROWN | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 5 82 | | 2b. HOUR
10⁵⁸ PM | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 1 82 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
--- 4 | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N.A. | | 12b. KIND OF BUSINESS OR INDUSTRY
N.A. | |
| 13a. STATE
MD | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
MONKTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Theodore Norment, Jr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
TINA Lynn BROWN | | | | 17. INFORMANT
ADDRESS Monkton Md. 21111 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
---- | | 17. INFORMANT
ADDRESS Tina L. Brown, 3145 Jarrettsville Pike | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
7469
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) SEVERE MULTIPLE CONGENITAL HEART DEFECT
DUE TO, OR AS A CONSEQUENCE OF
(c) HEART DEFECT
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 5 19 82 , to MAY 7 19 82 , that (I) (we) last saw the deceased alive on MAY 7 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Samuel G. Gog, M.D.
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
5/7/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LAUREL C. YAP, M.D. | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/11/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Church Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Blenheim Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Lemmon-Mitchell-Wiedefeld
ADDRESS
10 W. Padonia Rd | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 13 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

Items #16a-22a Film G568 6/30/82 r STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|-----------------------------------|--|---|--|--------------------------|--|---|--|------|--|----------|--|-------|--|-------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| Scipio | | F. | | Brown, Jr. | | | | 5 | | 18 | | 1982 | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | | | | |
| male | Col 2 | 10-13-1948 | | 33 | | YRS. | | | | 5 | | 18 | | 1982 | | 12:32 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| U.S.A. | | U.S.A. | | | | | | | | | | Baltimore City, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | Provident Hospital - DOA | | Laborer | | Warehouse | | | | | | | | | | | | | | | |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | | | | | |
| Maryland | | BALTO. | | YES | | 3702 Milford Ave. | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Scipio F. Brown SR. | | Flossie Warren | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| NO | | 219-52-7953 | | Mrs. Flossie Brown | | 3702 Milford Ave. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| 3040 IMMEDIATE CAUSE (a) Acute Heroin Intoxication | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | CITY OR TOWN | | | | COUNTY | | STATE | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE | | | | SIGNED | | | | | | | | | |
| Virginia L. Dolan | | | | M.D. Assistant | | | | 5-18-82 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | 111 Penn Street | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | COUNTY | | | | STATE | |
| Burial | | | | 5-22-82 | | | | Church Cem | | | | Crownland | | | | Cal | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Joseph L. Russ | | | | 2222 W. North Ave | | | | 2 JUN 2 1982 | | | | James J. [Signature] | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR YOUR INFORMATION, THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH IS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

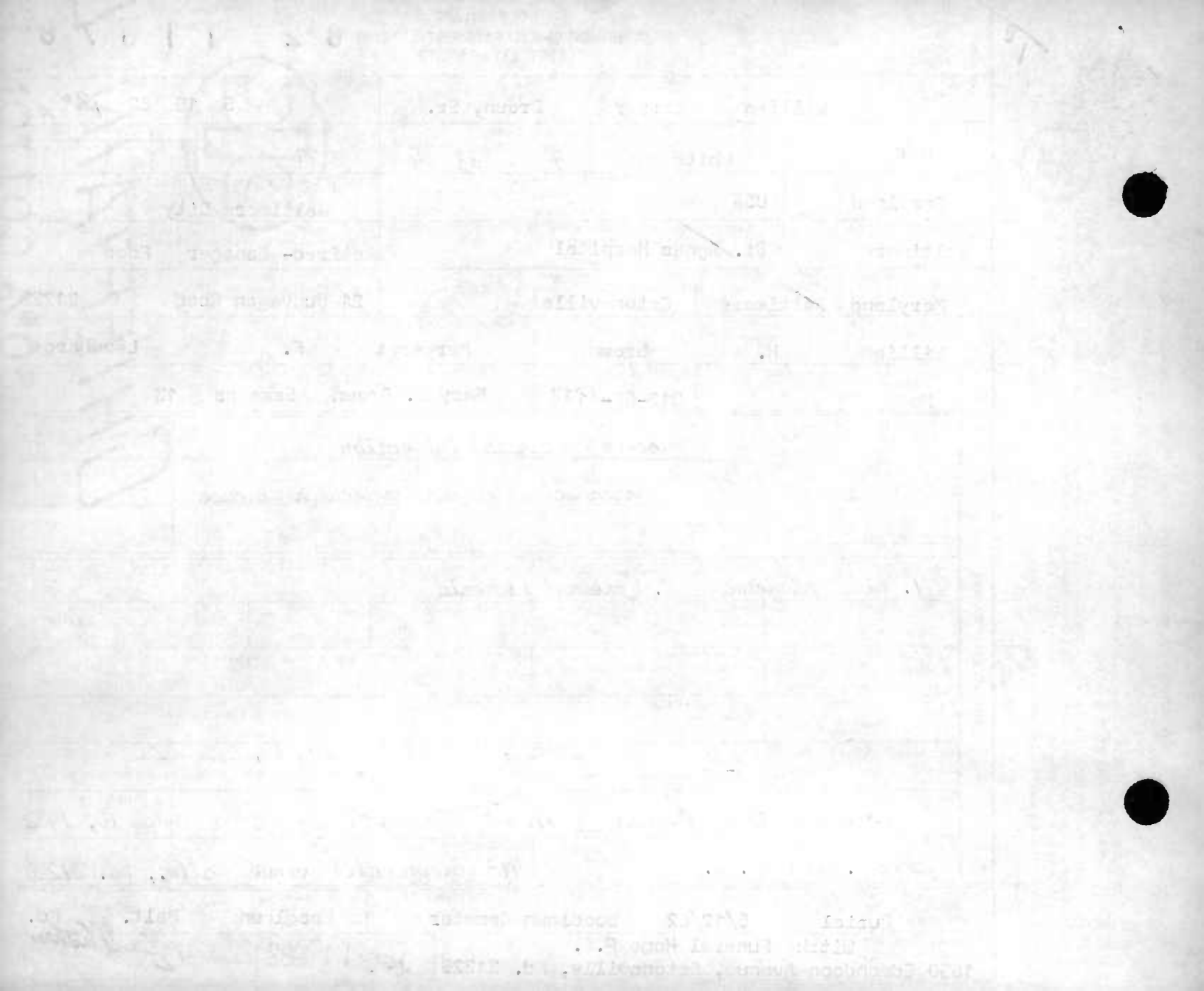
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 351-1234.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 7 8

REG. NO.

| | | | | | | | |
|--|-----------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 20. DATE OF DEATH | | 2b. HOUR | |
| | | FIRST MIDDLE LAST
William Henry Brown, Sr. | | MONTH DAY YEAR
5 10 82 | | 130 A M | |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 04 | | 6 AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired- Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Food | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Cetonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Brown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret F. Leonhardt | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-09-4012 | |
| 17. INFORMANT
Mary E. Brown | | ADDRESS
Same as # 13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u>
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic cardiovascular Disease</u>
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>1. Mild Emphysema 2. Cerebral Ischemia</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1977</u> to <u>May 10, 1982</u> , that (I) (we) last saw the deceased alive on <u>5-7-</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>James E. Rowe M.D.</u> | | 22c. DATE SIGNED
<u>May 10, 1982</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>James E. Rowe, M.D.</u> | | 22e. ADDRESS
<u>413 Commonwealth Avenue Balto., Md. 21228</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>5/12/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Woodlawn Balt. Md.</u> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>Witzke Funeral Home P.A.</u>
<u>1630 Edmondson Avenue, Catonsville, Md. 21228</u> | | | | 25a. DATE RECD. BY REGISTRAR
<u>MAY 11 1982</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 8 7 9
REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SAMUEL BRUTON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 12 82 | | 2b. HOUR
M
 | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 11 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
60 | |
| 7a. BIRTHPLACE
(COUNTRY)
Alabama | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3818 Beehler Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truckdriver | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jud Bruton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
220-03-1122 | | 17. INFORMANT
ADDRESS
Mrs. Ollie Mae Bruton 3741 Columbus Drive (15)
Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Possible acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c) Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4100 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Diabetes, H/o Myocardial Infarction | | | | | | | |
| 19a. DATE OF OPERATION
1/14 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Myocardial Infarction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11 11 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2 Hamill Rd Baltimore, Md. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14 , 19 82 , to 3/11 , 19 82 , that (I) (we) last saw the deceased alive on 3/11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. F. Thompson | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
MAY 17 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. F. Thompson | | 22e. ADDRESS
2 Hamill Rd | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Brown/Thompson F.H. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | | |
| 25b. ADDRESS
1913 W. Balto. St. | | | | 25c. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 1 | 8 | 8 | 0 | | |
|---|--|---|--|---|--|---|---|--|--|--|---|--|---|-----------------------------------|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Minnie C. BRYSON | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 6, 1982 | | | | | | | 2b. HOUR
6:30 a.m. | |
| 3. SEX
Female | | 4. RACE
Afro-American | | 5. DATE OF BIRTH
MONTH DAY YEAR
3/9/1918 | | | 6. AGE (IN YEARS (LAST BIRTHDAY))
64 | | | IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | IF UNDER 24 HRS.
HOURS MIN.
MD. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home - Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY
-----0----- | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | | 13e. STREET ADDRESS
3212 Brightwood Ave. | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Minus | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Arnett | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
-----0----- | | | 17. INFORMANT ADDRESS
Earl Bryson, 3212 Brightwood Ave. 21207 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DO TO, OR AS A CONSEQUENCE OF (b) Carcinoma of colon with metastasis to the liver
DO TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
April 17, 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that xx (this hospital) attended the deceased from April 17, 1982 , to May 6, 1982 , that (x) (we) lost saw the deceased alive on May 6, 1982 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
H. Bassiouny | | | | | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/6/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. Bassiouny | | | | | | | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
5/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Law Funeral Home 4611 Park Heights Ave. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 12 1982 | | | | | | | 25b. REGISTRAR'S SIGNATURE
Thome Jan... | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11881 | | | | | |
|--|--|-------------------------|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JEAN WOODSON BUCK | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-5-82 19 | | 2b. HOUR M | | | | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR 11/25/18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 5-5-82 19 | | 7d. HOUR M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lord Baltimore Hotel | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Artist-Commercial | | | | 12b. KIND OF BUSINESS OR INDUSTRY
News | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
American 2 Charles Center # 1701 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Neville Buck | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gladys Woodson | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
719 10 4550 | | | | 17. INFORMANT ADDRESS
Dr. Frank Buck, Lynchburg, Virginia | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9509 Trichloroethanol intoxication
IMMEDIATE CAUSE (a) Trichloroethanol intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 5/?/ 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self/ingested | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Lord Baltimore Hotel | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
20 W. Baltimore St. Baltimore Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | | | DATE SIGNED 5-6-82 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
5/10/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | | | | | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | 23e. DATE REC'D. BY REGISTRAR
MAY 10 1982 | | | | 23f. REGISTRAR'S SIGNATURE
James Santhorne | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--|--|--|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 1 8 8 2 | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| ETHEL B. BUCKINGHAM | | | | | | Buckingham | | MAY 5, 1982 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 2b. HOUR | |
| Female | | White | | February 22 1920 | | 62 | | 11:45 A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Westminster | | U.S.A. | | | | Baltimore City | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | St. Agnes Hospital | | housewife | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Carroll | | Westminster | | | | 523 Poplar Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| John Ray Musbaum | | Emma Basler | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No. | | 216-03-9167 | | Harry T. Buckingham | | 523 Poplar Ave Westminster, Md. 21157 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Stroke . Brain Death</u> | | | | | | | | | |
| 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post Coratid Endarterectomy</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uncontrollable Hypertension</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>arteriosclerosis Ulcerative Plaque Bilateral Carotid Arteries</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 4/30/82 | | Ulcerative Plaque Carotid. Hx of Stroke | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/2/82</u> 19 <u>82</u> , to <u>5/5/82</u> 19 <u>82</u> , that (I) (we) lost the deceased alive on <u>5/5/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| B. Parandian | | M.D. | | | | 5/5/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Bahman. B. PARANDIAN | | 3455 Wilkens Ave Balt - Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 5-8-82 | | Westminster Cemetery | | Westminster Carroll Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | 25. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Fletcher Funeral Home | | 251 East Main Street 21157 Westminster, Md. | | MAY 10 1982 | | | | | |

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101-101-0702



101-101-0702



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. People may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--|---|-----------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 1 8 8 3 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MONTA H. BUCKHOLT | | | | | MONTH 5 DAY 29 YEAR 82 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| MALE | | CAUC | | MONTH 3 DAY 10 YEAR 65 | | 77 YRS. | | 1:10 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| VA. | | U.S. | | | | BALTO. CITY | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTO. | | N. C. GEN. HOSP | | | | PAINTER | | RETIRED | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE | | | | | 13c. CITY OR TOWN | | | | |
| MD. | | | | | BALTO. | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | |
| NO | | | | | 218-05-3581 | | NIECE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Ca of the Lung</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>Dehydration, Parkinson's disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> , 19 <u>82</u> , to <u>5/29</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| <u>Veneranda G. Barnes M.D.</u> | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 5/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| VENERANDA G. BARNES | | | | | NORTH CHARLES GEN. HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | 6/1/82 | | CORRAINE PK. | | BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | |
| NAME ADDRESS | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| <u>Carl E. Chambers 3617 Madison Ave</u> | | | | | JUN 3 1982 <u>James J. [Signature]</u> | | | | |

MOBILE, ALA. BIRMINGHAM, ALA.
JAN 10 1910
TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
J. H. HARRIS
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to give an autopsy.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | 8 2 1 1 8 8 4
CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME
1st (ELLSWORTH MORDECAI M. ELLSWORTH BUCKINGHAM SR.) | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR HOUR
5 25 82 4:00p | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/21/94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MINA | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALT. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Md. Glass Corp. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Balto. Highlands | | 13d. INSIDE CITY LIMITS?
NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mordecai E. Buckingham | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Thomlinson | | 13e. STREET ADDRESS
2920 Illinois Avenue 21227 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
212-01-3377 | | 17. INFORMANT
ADDRESS
Bernice E. Pollard 4410 Norfen Road 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
4075
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Seizure</u>
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/25/82</u> 19 <u>82</u> to <u>5/25/82</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>5/25/82</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Mordecino D. A. Guernsey</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>5/25/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Mordecino D. A. Guernsey</u> | | | | 22e. ADDRESS
St. Agnes Hospital, 900 S. Caton Avenue 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Maryland | | | |
| 24. FUNERAL DIRECTOR
(NAME)
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 24b. ADDRESS
21229 | | 25a. DATE REC'D. BY REGISTRAR
MAY 28 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Kistner</u> | | | | | |

RECEIVED
JAN 22 1952
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

MAIL ROOM
RECEIVED
JAN 22 1952
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

RECEIVED
JAN 22 1952
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

RECEIVED
JAN 22 1952
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
MARIE T. (aka Bugkowski) BUCZKOWSKI | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 12, 1982 | | | | | 2b. HOUR
9:00 a.m. |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
December 3, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
704 S. Regester St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
Pickle Co. | | |
| 13a. STATE
Maryland | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
704 S. Regester St. 21231 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Louis Banaszkiwicz | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Stella Sobczynski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
- - - - - 213-09-5246 | | 17. INFORMANT ADDRESS
Joseph Buczkowski 704 S. Regester St. 21231 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe COPD (chronic obstructive pulmonary disease)
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 years | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 years | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 73 , to May 19 81 , that (I) was lost saw the deceased alive on May 19 81 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
A. B. Paulino | | | | | DEGREE
ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
May 12, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. A. B. Paulino | | | | | 22e. ADDRESS
Suite #410 Medical Arts Building
Read & Cathedral Sts. Baltimore Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cemetery Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME
George A. Weber & Sons Inc. 705 S. Ann St. 21231 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 13 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Paulino | | | |

3500

3500

3500

1

2

9

1

0203BP

1912, 1913, 1914

1915, 1916, 1917

1918, 1919, 1920

1921, 1922, 1923

1924, 1925, 1926

1927, 1928, 1929

1930, 1931, 1932

1933, 1934, 1935

1936, 1937, 1938

1939, 1940, 1941

1942, 1943, 1944

1945, 1946, 1947

1948, 1949, 1950

1951, 1952, 1953

1954, 1955, 1956

1957, 1958, 1959

1960, 1961, 1962

1963, 1964, 1965

1966, 1967, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

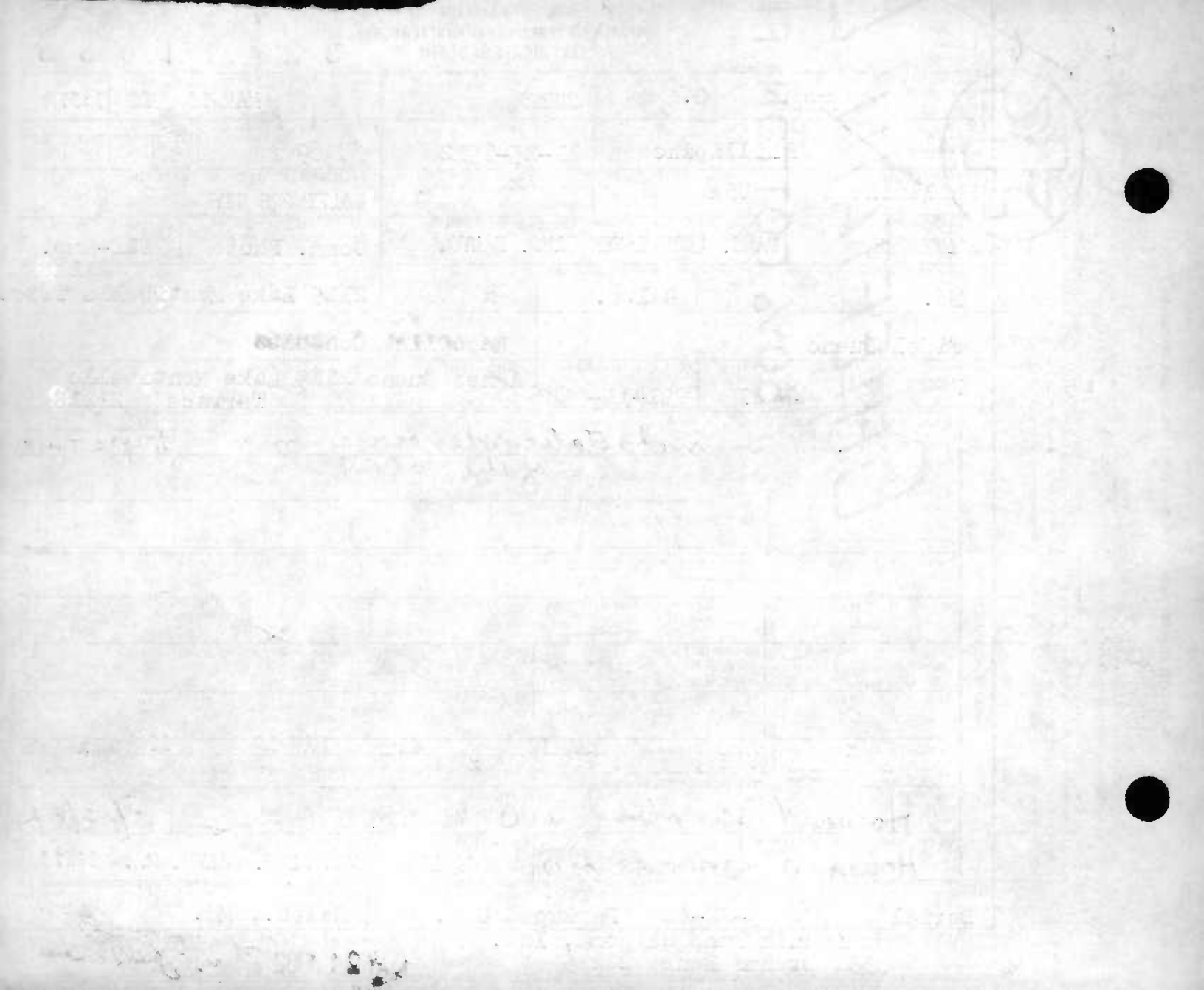
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 8 6
REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIDEL G. BUENO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 18 82 | | | 2b. HOUR
1:37P M | |
| 3. SEX
Male | | 4. RACE
Phillipino 8 | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-25-1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Phillipines | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC. LOCH RAVEN BLVD. BALTO. MD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Comm. Photo | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Self-Emp. | | 21214 - | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
2119 Lake Montebello Terr. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fidel Bueno | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marcelina Gonzales | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes WW II | | 16b. SOCIAL SECURITY NO.
091-14-0686 | | 17. INFORMANT
ADDRESS
Agnes Bueno 2119 Lake Montebello Terrace 21214 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic adenocarcinoma</u>
1539 DUE TO, OR AS A CONSEQUENCE OF <u>of the colon</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>17 yrs + mo</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1539</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MAY 12</u> , 19 <u>82</u> , to <u>MAY 18</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | |
| 22b. SIGNATURE
<u>Howard Jacobs MD</u> | | | | DEGREE
MD | | 22c. DATE SIGNED
<u>5/18/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>HOWARD JACOBS MD</u> | | | | 22e. ADDRESS
<u>3900 LOCH RAVEN BLVD. BALTO. MD. 21218</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc.
3331 Brehms Lane 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 21 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. ...</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to site.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 1 8 8 7 | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|-------------------------------|--|---|--|--|--|
| FOR
1. STATE
REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | |
| FIRST MIDDLE LAST
ANTHONY G. Bukowski Sr. | | | | | MONTH DAY YEAR
5-16-82 05 16 82 | | | | | 10:45 P M | | | | | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
11/12/19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Lever Bros. | | | | | | | |
| 13a. STATE
Md. | | | | | | | | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3605 Ravenwood Ave. 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stanislaus Bukowski | | | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Suzana Lazarewicz | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | | 16b. SOCIAL SECURITY NO.
(GIVEN OR DATES)
WW 11 | | 17. INFORMANT ADDRESS
Margaret C. Bukowski, same as above | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1991 Metastatic anaplastic cancer
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a: | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. - 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 4/30 19 82, to 5/16 19 82, that (I (we) last saw the deceased alive on 5/16 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Christopher K. Stoner | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/17/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Christopher K. Stoner | | | | 22e. ADDRESS
Union Memorial Hospital
Baltimore, MD | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(STATE)
Burial | | | | 23b. DATE
5/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus, Balto., Md. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1982 | | | | | | | | | | | |

14

WMOB V. 1/1/51

ATRIUM MOTION 200

WMOB V. 1/1/51

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| JEANNETTE Buratt | | | | May 12, 1982 | | 2:15a | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | APR. 26, 1924 | | 58 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | USA | | XX | | Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Maryland General Hospital | | SECRETARY | | DRUG CO. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | BALTO. | | BALTIMORE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3816 BYFIELD RD. #21207 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| JACOB | | ESTHER | | NO | | 217-12-7207 | | MR. PHILIP BURATT | |
| | | SATTler | | | | | | 3816 BYFIELD RD. BALTO., MD 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiorespiratory Arrest | | | | | | | | | |
| 2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Lymphoma | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from April 27, 1982, to May 12, 1982, that (X) (we) last saw the deceased alive on May 12, 1982, and that in (m) (aur) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | | | |
| Michael Hull, M.D. | | | | | | 5/12/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| | | | | C/O Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | MAY 13, 1982 | | FORBAND (LAZER RISSA SKLAR SEC.) | | ROSEDALE BALTO., MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., INC. | | | | MAY 17 1982 | | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified and called.

| FOR
1. STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 1 1 8 8 9
REG. NO. | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Annie M Bunch</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>5 30 82</i> | | 2b. HOUR
<i>5³⁰ P.M.</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>Black</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 10 12</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>69</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 26 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>South Carolina</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>CITY</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>O. Maryland Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>MD.</i> | 13b. COUNTY | 13c. CITY OR TOWN
<i>Baltimore</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>1704 Holbrook St.</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Lee Moses</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Corine -</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>Un Known</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
<i>Sandra Bunch. 1704 Holbrook St. Balt Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
<i>4810</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Right upper lobe pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 hrs.</i>
<i>1 day.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>S/P Scharlachoid Bleed.</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/20, 19 82</i> to <i>5/30, 19 82</i> , that (I) (we) lost
saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Norman Goldstein</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>5/30/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Norman Goldstein</i> | | 22e. ADDRESS
<i>O. Maryland Hospital
225. Greene St. Balt Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>6/4/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>King Memorial Park</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balto. Co. MD</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Wm. C. March F/H, Inc. 1101 E. North Ave</i> | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<i>James J. Thornton</i> | | | |

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JUN 3 1985
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 8 9 0 | |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
BABY/BOY | | | 2a. DATE OF DEATH
MAY 23, 1982 | | 2b. HOUR
9:55A M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 14 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 9 | IF UNDER 1 YEAR
MONTHS DAYS
9 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
THE JOHNS HOPKINS HOSPITAL | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | 13b. COUNTY
ANNE ARUNDEE | 13c. CITY OR TOWN
EDGEWATER | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
533 BROWN WOOD CT | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MARTIN BURCH | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JOYCE GOSNELL | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
160 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7718 METABOLIC DECOMPENSATION
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS AND PREMATUREITY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
PATENT DUCTUS ARTERIOSUS, HYALINE MEMBRANE DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22 19 82 , to 5/23 19 82 , that (I) (we) last saw the deceased alive on 5/23 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Daniel A Goldstein | | DEGREE
MD | | 22c. DATE SIGNED
5/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL A GOLDSTEIN | | 22e. ADDRESS
63972 THE JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
MAY 23, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
JOHNS HOPKINS | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1982 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR |
| WANDA | | M. | | BURCH | | MAY 18, 1982 | | 9:25AM | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| Female | | White | | February 8, 1914 | | 68 YRS. | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Pennsylvania | | United States | | | | Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Church Hospital | | | | House-wife | | Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | |
| Maryland | | - | | Baltimore | | YES | | 2126 E. Baltimore St. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| Frank - Trojak | | Agnes - Jarosz | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| NO - | | 216-18-7042 | | Lawrence Burch | | 2126 E. Baltimore St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) HEPATIC FAILURE | | | | | | | | | | WEEKS |
| 5728 DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 23 19 82 to MAY 18 19 82, that (I) (we) last saw the deceased alive on MAY 18 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| A. J. Helou, M.D. | | | | | | 5/18/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| A. J. HELOU, M.D. | | CHURCH HOSPITAL CORPORATION | | | | | | | | |
| | | 100 NORTH BROADWAY, BALTIMORE, MD | | | | 21231 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | May 21, 1982 | | Holly Hill Mem. Park | | - - Baltimore Co., Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Lilly & Zeiler Inc. 1901 Eastern Ave. | | MAY 19 1982 | | | | [Signature] | | | | |

Billy & Teller Inc. 1001 Western Ave.
 May 21, 1962 Holy Hill Farm, Md.
 - - Baltimore Co., Md.

NO - - - - - R10-1-10MS Lawrence Butch - 5122 E. Baltimore St.
 Bronx - - - - - Trojak Anna - - - - - Janusz
 Maryland - - - - - Baltimore - - - - - 4752 E. Baltimore St.
 Baltimore - - - - - Church Hospital House-ville Home
 Pennsylvania - - - - - United States X
 Female - - - - - Wife - - - - - February 6, 1961 - - - - - 58
 Baltimore City

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--------------------|---|----------------------|---------------------------------------|-----------|---|----------|----------|----------|
| 1. FOR STATE REGISTRAR | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| Harris Addison Burgess Jr | | 5 | | 26 | | 82 | | | | | |
| 7. SEX | 8. RACE | 9. DATE OF BIRTH | 10. AGE (IN YEARS) | 11. IF UNDER 1 YR. | 12. IF UNDER 24 HRS. | 13. DATE PRONOUNCED DEAD | 14. MONTH | 15. DAY | 16. YEAR | 17. HOUR | 18. MIN. |
| male | Col. v | 6-20-1955 | 26 | | | 5 | 26 | 82 | | 12:13 | |
| 19. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 20. CITIZEN OF WHAT COUNTRY? | 21. MARRIED | 22. NEVER MARRIED | 23. WIDOWED | 24. DIVORCED | 25. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Balto. Md. | U.S.A. | | | | | AM
Baltimore City MD. | | | | | |
| 26. CITY OR TOWN OF DEATH | 27. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 28. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 29. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | Sinai Hospital | Unemployed | | | | | | | | | |
| 30. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 31. STATE | 32. COUNTY | 33. CITY OR TOWN | 34. INSIDE CITY LIMITS? | 35. STREET ADDRESS | | | | | | |
| Maryland | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5000 Cordelia Ave. | | | | | | |
| 36. FATHER'S NAME | 37. MOTHER'S MAIDEN NAME | 38. INFORMANT | | 39. ADDRESS | | | | | | | |
| Harris Edison Burgess Jr | NAT Lee Wilson | Mrs. Natlee Parker | | 5000 Cordelia Ave. | | | | | | | |
| 40. WAS DECEASED EVER IN U.S. ARMED FORCES? | 41. SOCIAL SECURITY NO. | 42. INFORMANT | | 43. ADDRESS | | | | | | | |
| | 217-66-7890 | Mrs. Natlee Parker | | 5000 Cordelia Ave. | | | | | | | |
| 44. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot wound of chest Weapon: Unspecified | | | | | | | | | | | |
| 9654 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 45. DATE OF OPERATION | | | | 46. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 47. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 48. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 49. TIME OF INJURY | | | | 50. HOW INJURY OCCURRED | | | |
| 11:28 PM 5/25/82 | | | | subject shot | | | | | | | |
| 51. INJURY OCCURRED | | | | 52. PLACE OF INJURY | | | | 53. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | street | | | | 3600 Blk Howard Park Ave, Baltimore MD | | | |
| 54. I certify that I took charge of the remains described above, held on | | | | | | | | | | | |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| death resulted from: <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| 55. ACTUAL SIGNATURE | | | | 56. TITLE (SPECIFY) | | | | 57. DATE SIGNED | | | |
| Hormez R. Guard, M.D. | | | | Assistant | | | | 5/26/82 | | | |
| 58. EXAMINER'S NAME | | | | 59. ADDRESS | | | | 60. DATE REC'D. BY REGISTRAR | | | |
| Hormez R. Guard, M.D. | | | | 111 Penn Street, Balto., MD 21201 | | | | JUN 2 1982 | | | |
| 61. BURIAL, CREMATION, REMOVAL | | | | 62. DATE | | | | 63. NAME OF CEMETERY OR CREMATORY | | | |
| B | | | | 6/1/82 | | | | Cedar Hill Ce | | | |
| 64. FUNERAL DIRECTOR | | | | 65. DATE REC'D. BY REGISTRAR | | | | 66. REGISTRAR'S SIGNATURE | | | |
| Joseph C. Rynn | | | | JUN 2 1982 | | | | James Santhana | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7- 1 1 8 9 3 | |
| 1. DECEASED NAME (TYPE OR PRINT) Ella Burrell | | | | | | | | | | 2a. DATE OF DEATH 5-27-82 | |
| 3. SEX F 4. RACE Black 5. DATE OF BIRTH 9 16 04 6. AGE (IN YEARS) 77 7. IF UNDER 1 YR. NO 8. IF UNDER 24 HRS. NO | | | | | | | | | | 2b. DATE OF DEATH 5-27-82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 804 W. Lexington Street 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Retired 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE Md 13b. COUNTY Balto. 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES 13e. STREET ADDRESS 804 W. Lexington Street | | | | | | | | | | | |
| 14. FATHER'S NAME Abraham Gilmore 15. MOTHER'S MAIDEN NAME Amanda ? | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16b. SOCIAL SECURITY NO. 215 09 4900 17. INFORMANT Isaiah E. Burrell ADDRESS 1123 Darley Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION 111 Penn Street | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell M.D. Assistant TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE 5-27-82 SIGNED | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 6-1-82 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. 23d. LOCATION Baltimore, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Brown/Thompson F. H. ADDRESS 1913 W. Balto. St. 25a. DATE REC'D. BY REGISTRAR JUN 1 1982 25b. REGISTRAR'S SIGNATURE Thomas J. Kishner | | | | | | | | | | | |

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 1 8 9 4

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Rosie Burrell | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-20-82 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
Col. | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-30-1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2023 Clifton Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Maryland CITY OR TOWN BALTO. | | | | | 13b. COUNTY | | 13c. STREET ADDRESS
2023 Clifton Ave | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Sewell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kosana Pasquel | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
217-20-1154 | | 17. INFORMANT
ADDRESS
Mr. Richard Burrell 2023 Clifton Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer Colon & mets
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 80 , to May 10 19 82 , that (I) (we) last saw the deceased alive on 4-23-82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
David L. M. C. DEGREE M.D. | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-25-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David L. M. C. | | | | | | 22e. ADDRESS
10219 S. ... | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. National MemPK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Prince Georges, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ ADDRESS
2222 W. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. ... | |

MEDICAL CERTIFICATION

17
(17)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filer, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 8 9 5 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MILDRED C. (NICHOLS) BUSHROD | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 26 82 | | 2b. HOUR 2:18 PM | |
| 3. SEX FEMALE | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 5 12 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Of Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS 2814 Riggs Avenue | | 13b. CITY OR TOWN Baltimore | | 13c. STATE Maryland | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James F. Carroll, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie E. Curtin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | |
| 17. INFORMANT ADDRESS Donna N. Waters 1126 Braddish Avenue | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
5191
DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHIAL STENOSIS
DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY RESECTION + RADIOTHERAPY
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 WEEKS
YEARS
5 YEARS | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
SMALL BOWEL OBSTRUCTION + DYSFUNCTION | | | |
| 19a. DATE OF OPERATION 3/10/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BOWEL OBSTR 2° ADHESIONS | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) this hospital attended the deceased from 3/19 , 19 82 , to 5/26 , 19 82 , that (I) was lost saw the deceased alive on 5/26 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) will (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE T. E. HUBBINS, MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. E. HUBBINS, MD | | | | 22e. ADDRESS 414 BRB 29 S. GREENE ST BALTO MD 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 6/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY Pinelawn Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, Maryland | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Patten | |

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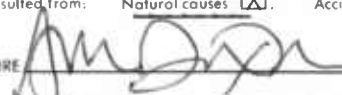

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1000 1000 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|-----------------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) HILDA E. BUTH | | | 2a. DATE OF DEATH
KNOWN <input checked="" type="checkbox"/> ESTI-
MATED <input type="checkbox"/> 5 22 19 82 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH Dec. DAY 22 YEAR 1899 | 6. AGE (IN YEARS)
LAST BIRTHDAY 82 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 HOURS 0 MIN 0 | 7c. DATE
PRONOUNCED
DEAD 5 22 19 82 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3939 Roland Ave. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Apartment Mgr. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3939 Roland Ave. Apt. 303 |
| 14. FATHER'S NAME
FIRST Eugene R. MIDDLE Watts LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST Minna MIDDLE Walters LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579 09 3680 | | 17. INFORMANT
Adele L. Lambert ADDRESS
Princeton, N.J. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED 5-23-82 | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | |
| 22. BURIAL, CREMATION, REMOVAL
(TYPE) Cremation | 23b. DATE
5/24/82 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Park | | 23d. LOCATION
CITY OR TOWN Baltimore, Maryland COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME Burgee Funeral Home ADDRESS Baltimore, Md. 21211 | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1982 | | 25b. REGISTRAR'S SIGNATURE
 | |

Chinese Funeral Home
Baltimore, Md. 21211

Baltimore, Maryland

2/24/82

Westview Mortuary

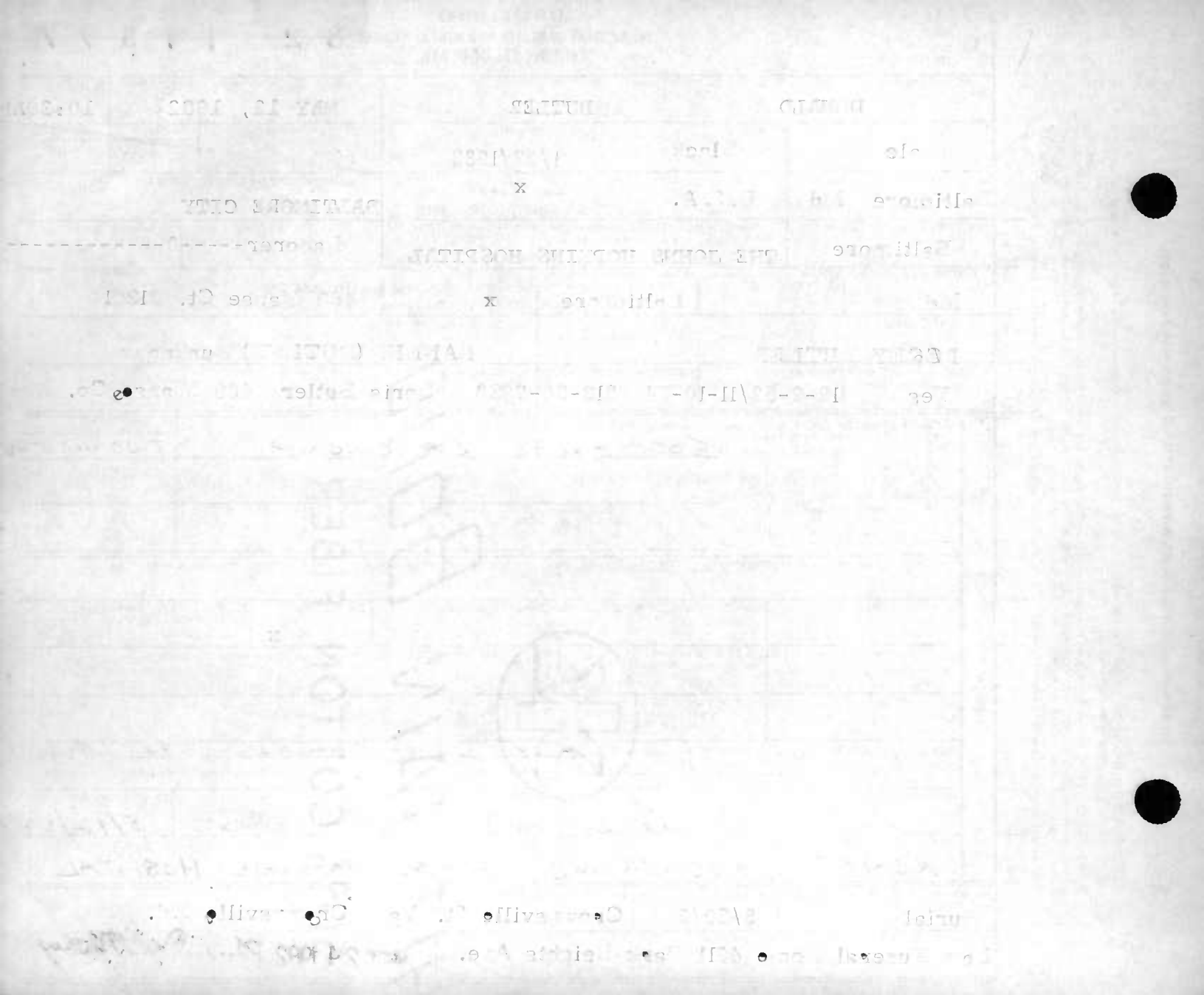
Remotion

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 8 9 7 | |
|--|--|--|--|---|---|---|--|--|---|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DONALD BUTLER | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 12, 1982 | | 2b. HOUR
10:39AM | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1/22/1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS
0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore Md | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK, BUSINESS, OR SERVICE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
INDUSTRY | | | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
460 Manse Ct. 21201 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LOVEY BUTLER | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NANNIE (BUTLER) unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, AND OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(YES, GIVE YEAR OR DATES)
12-2-52/11-10-54 | | 17. INFORMANT
ADDRESS
212-30-7828 Doris Butler, 460 Manso Co. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ESOPHAGEAL CARCINOMA
1509
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
TWO MONTHS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14 , 19 82 , to 5/12 , 19 82 , that (I) (we) last saw the deceased alive on 5/12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Kleiner, MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
5/12/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT C. KLEINER, MD | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville St. Va | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Law Funeral Home 4611 Park Heights Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1982 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 9 8

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Vincent A Byrnes</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>5 8 82</i> | | 2b. HOUR
<i>7 4</i> M | |
| 1. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3 2 '07</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
<i>75</i> | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>University of Maryland</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Body Shop Owner</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>-</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>---</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Vincent Byrnes</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Annie Carey</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WW I 213-01-2327</i> | | 17. INFORMANT
ADDRESS
<i>Mr. Thomas Byrnes 21133 8735 Meadow Heights Rd., Randallstown, MD</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>disease lymphocytic lymphoma</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>DVT Leg, Basal Cell CA</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Sq. cell CA to the right side of the neck, Sp Rt post comm. artery aneurysm</i> | | | | | |
| 19a. DATE OF OPERATION
<i>---</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>---</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>---</i> | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>University of Maryland</i> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/6</i> , 19 <i>82</i> , to <i>5/8</i> , 19 <i>82</i> , that (I) (we) lost
saw the deceased alive on <i>5/8</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Michael Royan</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ANDAL RAJARAM</i> | | 22e. ADDRESS
<i>University of Maryland</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>5/14/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore City MD</i> | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
<i>May 14 1982 Thomas J. [Signature]</i> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133</i> | | | | | |

BP

COLLECTION FIBER



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 8 9 9

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|-------------------------------------|--------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Sarah E. Cager | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 4, 1982 | | 2b. HOUR
3:43a M | | | | | | | | |
| 1. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 14 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
927 Claymont | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom Shaw | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Shaw | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-20-5629 | | 17. INFORMANT ADDRESS
Hilda Palmer 827 Cator Avenue | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
1790
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>uterine SARCOMA metastatic</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>to lungs</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | | | | | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 19 82, to 4/15, 19 82, that (I/we) last saw the deceased alive on 4/15, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Enrique Hernandez</i> | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/4/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Enrique Hernandez | | | | | | 22e. ADDRESS
Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 5 1982 | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | |

Baltimore City

Maryland General Hospital

Baltimore

Office of the Surgeon General



Johns Hopkins Hospital

Dr. Charles H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

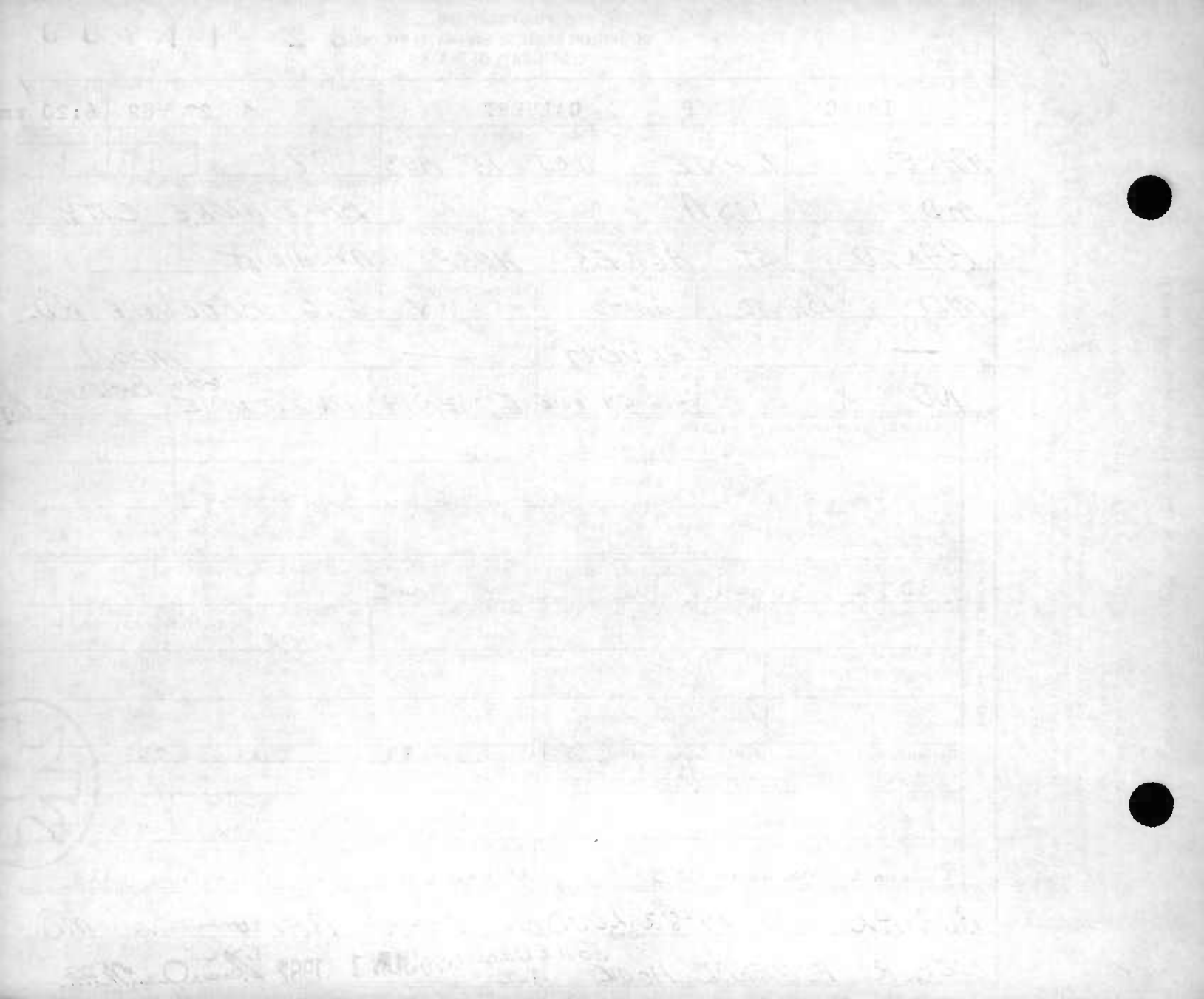
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|--|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ISAAC P CALVERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 27 82 | | 2b. HOUR
6:20 PM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT 15 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
— — — | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
— — — | | 13e. STREET ADDRESS
626 BRAESIDE RD. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(SEE INSTRUCTIONS) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
212-09-8518 | | 17. INFORMANT
EUGENIA McKECHNIE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Obstructive Pulmonary Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) —
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
DIC, Sepsis, Pneumonia, MI | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 82 , to 5/27 , 19 82 , that (I) (we) last saw the deceased alive on 5/27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Ricardo L. Machado | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/27/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ricardo L. Machado M.D. | | 22e. ADDRESS
ST. Agnes Hospital BALTIMORE, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO BALTO MD. | | 23e. DATE REC'D. BY REGISTRAR
JUN 1 1982 | | | | |
| 24. FUNERAL DIRECTOR
NAME
WEBER FUNERAL HOME | | ADDRESS
5311 EDMONDSON AVE | | 25. REGISTRAR'S SIGNATURE
James J. [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 0 1 | |
|---|--|---|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) LOUIS CAPLAN | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 5-9-82 | | 2b. HOUR
9²⁵ AM | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 12 25 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY) BALTO MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levin Dale Geriatric Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
US. GOVT. | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
Balt | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
APT. 1-C
1 COBBLESTONE CT. #21215 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DAVID CAPLAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JENNIE UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-24-7368A | | 17. INFORMANT
MRS. BESSIE CAPLAN | | | | 17b. ADDRESS
1 COBBLESTONE CT., APT. 1C #21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1991 METASTATIC ADENOCARCINOMA, WIDESPREAD
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) PRIMARY SITE UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1982 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CARCINOMA PROSTATE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 05-04 , 19 82 , to 05-09 , 19 82 , that (I) (we) lost
saw the deceased alive on 05-09 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Bo ZAW-WIN, M.D. | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
05-09-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bo ZAW-WIN, M.D. | | | | 22e. ADDRESS
LEVINDALE GERIATRIC CTR BALTIMORE 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | | 23b. DATE
MAY 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE RECEIVED BY REGISTRAR
MAY 12 1982 | | | | 25b. SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 0 2

REG. NO.

| | | | |
|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN H CAREY | | 2a. DATE OF DEATH MONTH DAY YEAR
5/23/82 7:55 PM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Dec 10, 1899 | 6. AGE (IN YEARS LAST BIRTHDAY)
82 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Paving Foreman | 12b. KIND OF BUSINESS OR INDUSTRY
Batt. City |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas CAREY | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Delia Webb | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
214-40-5615 | 17. INFORMANT
Miss Kathryn E Carey | ADDRESS
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
4310
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Cerebral Hematomas</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | |
| 19a. DATE OF OPERATION
N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17/82 to 5/23/82, that (I) (we) last saw the deceased alive on 5/23/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Daniel S. Miner | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
5/23/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL S MINER | 22e. ADDRESS
UM Hospital Belts | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
5/26/82 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens Of Faith | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME
Leonard J Ruck Inc. Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1982 | 25b. REGISTRAR SIGNATURE
Frances J. [Signature] |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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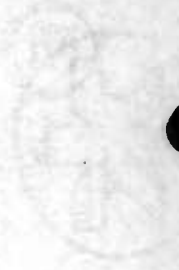


| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 0 3 | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|---------------------|--|-------|--|------|--|----------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Ida | | M. | | Carroll | | | | 5-13-82 | | | | | | | | 4:45 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Female | | Black | | 7 MONTH 4 DAY 34 YEAR | | 48 YRS | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| N.C. | | U.S. | | | | Balto. City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | J.L. Deaton 611 S. Charles St | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. COUNTY | | 13d. CITY OR TOWN | | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS | | | | | | | |
| MD. | | | | | | Balto. City | | | | 611 S. Charles St. | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Elijah Carroll | | unknown | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| no | | | | Mary Wing | | 121 Winters Lane Balto. Md | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | METASTASIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 1539 | | DUE TO, OR AS A CONSEQUENCE OF | | (b) | | CANCER OF COLON | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | renal failure | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | |
| C. Wainwright | | MD | | ATTENDING PHYSICIAN | | MEDICAL STAFF PHYSICIAN <input type="checkbox"/> | | 5/13/82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Cremation | | 5/17/82 | | Westview Mem. Park | | Balto. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| C. Wainwright | | 2700 Edmondson Ave. | | MAY 18 1982 | | James E. Hinton | | | | | | | | | | | |

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DEPARTMENT OF AGRICULTURE
UNITED STATES GOVERNMENT

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 1 9 0 4
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ZYLNE CARTER | | 2a. DATE OF DEATH MONTH DAY YEAR
05/11/82 | | 2b. HOUR
2:55pm | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7/31/24 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH
BALTO... MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House Wife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY
City | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Rigby Stukes | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Thompson | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
818-26-9859 | | 17. INFORMANT ADDRESS
Samuel Carter Sr. 3 S. Hilton St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) D.M., hypertension
2500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-3-82 , 19 82 , to 5-11 , 19 82 , that (I) (we) lost
saw the deceased alive on 5-11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kenneth Stein & | | | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn AA Md. | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
MAY 18 1982 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chas. A. Rice FSPA 1300 Eutaw Pl. | | | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8211905 | |
|--|--|----------------------|---|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BETTY A. CASSADY | | | | | | | | | | 2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-29-82 | |
| 1. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 28 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-29-82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1711 N. Calvert Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1711 N. Calvert Street 21202 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hoffman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 215-28-6750 | | 17. INFORMANT ADDRESS Deborah P. Cassady 2624 St. Paul Street 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292
(b) Due to, or as a consequence of
(c) Due to, or as a consequence of
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Koroll</i> | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. | | | | ADDRESS 111 Penn Street | | | | DATE SIGNED 5-30-82 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. Hatcher</i> | | | |



RECEIVED
NOTICE
COTTON

Handwritten signature or text, possibly "J. B. Smith".

Handwritten text at the bottom of the page, possibly a date or address.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 - 1 1 7 9 0 6 | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles Cephus | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 21 82 | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 12 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
Balt | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | |
| 13a. STATE
MD | | 13b. COUNTY
Balt | | 13c. CITY OR TOWN
BALTO. | | 13e. STREET ADDRESS
3314 Dorchester Rd | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leonard Cephas | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Estella Cephas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
2 18 0 9 4 6 7 8 | | 17. INFORMANT ADDRESS
3314 Dorchester Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respir arrest
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) metastatic adenocarcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/23 , 19 82 , to 5/21 , 19 82 , that (I) (we) lost saw the deceased alive on 5/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
W. Kellner | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. Kellner | | | | 22e. ADDRESS
Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
5-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
LEROY O. DYETT & SON 4600 Liberty Hgts. | | | | 25a. DATE RECEIVED BY REGISTRAR
MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Nuthen | |

Unit No. 726104



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UNITED STATES DEPARTMENT OF JUSTICE
LIBRARY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 0 7
REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Albert M. Chalkley | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-30-82 | | 2b. HOUR
9:30 AM |
| 3. SEX
male | 4. RACE
Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR
8-28-09 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
72 yrs. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE OF DEATH)
Deaton Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian | | 12b. KIND OF BUSINESS OR INDUSTRY
Faith Luth. Church |
| 13a. STATE
MD. | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Albert A. Chalkley | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary E. Cartlich | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
212-05-2499 | | 17. INFORMANT ADDRESS
Mary E. Price, 1233 Neighbors Ave. 21237 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
3109 IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) CBS
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
2 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/30/82 to 5/30/82 , that (we) lost saw the deceased alive on 5/30/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
J.A. Glaser | | DEGREE
Attending Physician | | 22c. DATE SIGNED
JUN 4 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
6-2-82 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24. FUNERAL HOME (NAME)
Schmunek Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR
JUN 4 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Hester | |
| 24. FUNERAL HOME (ADDRESS)
3331 Brehms Lane 21213 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11908 | | |
|--|---------|------------------------------|---|--|------------------------------------|---|--|---|-----------------------------------|---|--------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | | |
| WILLIAM H. CHALMERS | | | | | | MONTH DAY YEAR | | | 5 3 19 82 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | |
| Male | White | MONTH DAY YEAR | LAST BIRTHDAY | MONTHS | DAYS | MONTH DAY YEAR | | | 9:58 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD | | | |
| Maryland | | USA | | | | Baltimore City | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | 2303 Pentland Dr. | | | Banking | | | Mercantile | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | |
| William Chalmers | | | | | | Pearl Saunders | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | |
| yes | | | WW II | | | 216-03-8109 | | | Mary Chalmers, 2303 Pentland Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> | | | | | | | | | | | | |
| 4029 | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | |
| | | | | M.D. Assistant MEDICAL EXAMINER | | | | 5-3-82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | COUNTY STATE | |
| Burial | | | 5-6-82 | | Parkwood Cem. | | | Parkville | | | Balto., Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Lassahn Funeral Home, Inc. | | | | | | 6 1982 | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be examined with care and that the medical certificate must be signed and returned by the hospital or attending physician. The law requires that death certificates be examined with care and that the medical certificate must be signed and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be used in connection with the funeral. It should be detached for use as the burial-transit permit. Then please remove certain portions of the certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be signed and returned by the hospital or attending physician.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 0 9

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM CHAMBERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 20, 1982 | | 2b. HOUR
09:24 AM | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 23 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
43 S. Kossuth Street | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfred | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kathryn | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-18-8756 | | 17. INFORMANT
Bertha Chambers | | ADDRESS
1606 N. Vincent St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPERGILLUS PNEUMONIA
1173
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b) LEUKOCYTOCLASTIC VASCULITIS
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
2 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from March 5, 1982 , to May 19, 1982 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on May 20, 1982 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W. Givies McKenna M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
May 20 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MCKENNA | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stephens Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
St. Stephens MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H, Inc. 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |

X

5221 A.C. Yarn

Items #18a-22a Film G568 6/25/82 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11910

| | | | | |
|--|-------------------------|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
John W Chandler | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
5 11 1982 | | 2b. HOUR
M
6:PM |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
3/17/17 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
65 | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN
5 14 19 82 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
32 S. Broadway | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER |
| 13a. STATE
MD. | | 13b. CITY OR TOWN
BALTO. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN CHANDLER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NORA LONG | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
236 05 0401 | | 17. INFORMANT
ADDRESS
709 SANDRA RICHMOND STANFORD CT |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
_____ |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION
5/21/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Arteriosclerotic Cardiovascular Disease | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
Margarete J. Korell | | TITLE (SPECIFY)
M.D. Assistant | | DATE SIGNED
5/15/82 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street, Balto. MD 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY
CROWNSVILLE ST. CEM. |
| 24. FUNERAL DIRECTOR
NAME
J.G. CONNELLY | | ADDRESS
300 MACE | | 25a. DATE RECEIVED BY REGISTRAR
MAY 25 1982 |
| 25b. REGISTRAR'S SIGNATURE
Harvey J. Hall | | 25c. REGISTRAR'S SIGNATURE
Harvey J. Hall | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP
 DHMH-17
 (VR A15 ME (5))
 15M 2/80

159

1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 1 1 | |
|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| FIRST MABEL MIDDLE CHANDLER LAST | | | | May 8, 1982 7:21P M | |
| 3 SEX FEMALE | | 4 RACE N V | | 5. DATE OF BIRTH MONTH DAY YEAR 9 14 1900 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | | | 13b. COUNTY BALTO. | |
| 13c. CITY OR TOWN | | | | 13d. STREET ADDRESS 445 WATTY COURT | |
| 14. FATHER'S NAME FIRST ARCHER MIDDLE BLACKWELL LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST JOSEPHINE MIDDLE JENNINGS LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 217-20-1773 | |
| 17. INFORMANT JAMES CHANDLER | | | | ADDRESS 4663 PARK HYS BALTO. MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Sepsis and Aspiration Pneumonia | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure, Acidosis | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| Left Pleural Effusion | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19, 1982, to May 8, 1982, that x (we) last saw the deceased alive on May 8, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above x (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph O Gent MD | | | | 22c. DATE SIGNED 5/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Gent, M.D. | | | | 22e. ADDRESS c/o Maryland General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 5/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Calvary | |
| 23d. LOCATION CITY OR TOWN A.A. MD | | 23e. STATE | | | |
| 24. FUNERAL DIRECTOR NAME Chatman #14 1701 McCulloch St | | | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1982 | |
| 25b. REGISTRAR'S SIGNATURE James Jam Martin | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 1 2 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| LLOYD WASHINGTON CHASE | | | | 5 18 82 4 05 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | BLACK | | 7 29 04 | | 77 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MD | | U.S. | | | | BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | LUTHERAN HOSPITAL | | RETIRED | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| MD | | | | BALTIMORE | | 807 DUKELAND ST | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | | |
| Walter | | Mary | | 807 N. Duikeland St. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | 218098213 | | Mary Chase | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of the rectum</u>
1541
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Pneumonia, Diabetes mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/18/82</u> to <u>5/18/82</u> , that (I) (we) last saw the deceased alive on <u>5/18/82</u> and that in (my) (our) opinion death occurred on the dated and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Cyent</u> | | | | | | 5/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| KYAW NYUNT | | LUTHERAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 5/22/82 | | Meadowridge Mem. Pk. | | Balto. Co. MD | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | MAY 20 1982 | | <u>James J. North</u> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11913 | |
|---|--|--|--|--|--|--|--|--|--|-------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 20. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) CHESTER, CHERRY | | | | | | | | | | 21. DATE OF DEATH | |
| 2. SEX Male | | | | | | | | | | 22. DATE OF DEATH | |
| 3. RACE White | | | | | | | | | | 23. DATE OF DEATH | |
| 4. DATE OF BIRTH MAY 27 1926 | | | | | | | | | | 24. DATE OF DEATH | |
| 5. AGE (IN YEARS) 56 YRS. | | | | | | | | | | 25. DATE OF DEATH | |
| 6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | | | | | | | | | 26. DATE OF DEATH | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | | | | | | | | | 27. DATE OF DEATH | |
| 8. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 28. DATE OF DEATH | |
| 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 29. DATE OF DEATH | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | | | | | | | 30. DATE OF DEATH | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Baltimore City Hospital | | | | | | | | | | 31. DATE OF DEATH | |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROFESSIONAL ENGINEER | | | | | | | | | | 32. DATE OF DEATH | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) VIRGINIA | | | | | | | | | | 33. DATE OF DEATH | |
| 14. CITY OR TOWN 13. CITY OR TOWN ALEXANDRIA | | | | | | | | | | 34. DATE OF DEATH | |
| 15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 35. DATE OF DEATH | |
| 16. STREET ADDRESS 907 CHURCH ST. | | | | | | | | | | 36. DATE OF DEATH | |
| 17. FATHER'S NAME FIRST MIDDLE LAST WALTER CHERRY | | | | | | | | | | 37. DATE OF DEATH | |
| 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECILIA NOWAK | | | | | | | | | | 38. DATE OF DEATH | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | | | | | | | 39. DATE OF DEATH | |
| 20. SOCIAL SECURITY NO. 14516-3122 | | | | | | | | | | 40. DATE OF DEATH | |
| 21. INFORMANT ADDRESS MRS. A. SHIELDS, 532 CENTRAL AVENUE, HARRISON, N.J. 07029 | | | | | | | | | | 41. DATE OF DEATH | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | 42. DATE OF DEATH | |
| 23. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | 43. DATE OF DEATH | |
| 24. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | | 44. DATE OF DEATH | |
| 25. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | 45. DATE OF DEATH | |
| 26. DATE OF OPERATION | | | | | | | | | | 46. DATE OF DEATH | |
| 27. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 47. DATE OF DEATH | |
| 28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 48. DATE OF DEATH | |
| 29. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 49. DATE OF DEATH | |
| 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | 50. DATE OF DEATH | |
| 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | 51. DATE OF DEATH | |
| 32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 52. DATE OF DEATH | |
| 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 53. DATE OF DEATH | |
| 34. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | 54. DATE OF DEATH | |
| 35. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | 55. DATE OF DEATH | |
| 36. ACTUAL SIGNATURE Virginia L. Dolan | | | | | | | | | | 56. DATE OF DEATH | |
| 37. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | 57. DATE OF DEATH | |
| 38. EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | | | | | | | 58. DATE OF DEATH | |
| 39. ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | 59. DATE OF DEATH | |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | | | | 60. DATE OF DEATH | |
| 41. DATE 5-7-82 | | | | | | | | | | 61. DATE OF DEATH | |
| 42. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM. | | | | | | | | | | 62. DATE OF DEATH | |
| 43. LOCATION CITY OR TOWN COUNTY STATE EAST HANOVER MORRIS N.J. | | | | | | | | | | 63. DATE OF DEATH | |
| 44. FUNERAL DIRECTOR NAME ADDRESS Freeman's Fun'l Services 620 Schenck Ave | | | | | | | | | | 64. DATE OF DEATH | |
| 45. DATE REC'D. BY REGISTRAR MAY 9 1982 | | | | | | | | | | 65. DATE OF DEATH | |
| 46. REGISTRAR'S SIGNATURE | | | | | | | | | | 66. DATE OF DEATH | |

May 8 1900

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 1 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|-----|---|---------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Mary V. Cherry</i> | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR
2:45 PM | | |
| 3. SEX
<i>F.</i> | | 4. RACE
<i>B.</i> | | 5. DATE OF BIRTH | | MONTH | | DAY | | YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY</i> MD. | | 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SOUTH BALT. GEN. HOSP.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>NONE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>2602 Round Rd. Apt. 3</i> | | 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>212 28 9162</i> | | 17. INFORMANT
<i>Chart</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiac failure</i>
1509
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Carcinoma esophagus with metastases to mediastinum</i>
(c) <i>Myocardial infarction, atherosclerosis</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION
<i>4/15/82</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>cancer esophagus</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/3/82</i> , 19 <i>82</i> , to <i>5/7/82</i> , 19 <i>82</i> , that (I) (we) lost
saw the deceased alive on <i>5/7/82</i> , 19 <i>82</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<i>[Signature]</i> | | 22c. DATE SIGNED
<i>5/7/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>BADRE</i> | | 22e. ADDRESS
<i>SBGH</i> | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>5/12/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Calvary</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore MD</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>E.L. Phillips</i> | | ADDRESS
<i>1721 N. Monroe St.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 10 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHILDEAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 1 9 1 5
CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Lillian Lee CHEWNING
<i>Lillian Chewning</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 15, 82 | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
Mar 19, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 | | 2b. HOUR
5:00 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
City Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 13a. STATE
MD | | | | | 13b. CITY OR TOWN
Glen Burnie | | 13c. STREET ADDRESS
6644 Whitmore Ct. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eddie Whitlock | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Dillard | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
XXXXXXXX 228/14/1940 | | 17. INFORMANT ADDRESS
Mr. William P. Chewning (son) Severn, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 5/15 , 19 82 , that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
H. Barnes
DEGREE MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARNES | | | | 22e. ADDRESS
Balto City Hosp | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(S) Burial | | 23b. DATE
18 May 82 | | 23c. NAME OF CEMETERY OR CREMATORY
Epiphany Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Odenton, AA MD | | | |
| 24. FUNERAL DIRECTOR
NAME Singleton Funeral Home ADDRESS Glen Burnie, MD | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 1 6 | |
|--|--|---|---|---|---|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) KAP DONG CHOE | | | 2a. DATE OF DEATH | | 2b. HOUR |
| 3 SEX Female | | | 4 RACE Oriental | | 5 DATE OF BIRTH |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea | | | 7b. CITIZEN OF WHAT COUNTRY? Korea | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 |
| 10. CITY OR TOWN OF DEATH Balto. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of Md. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 13a. STATE Md. | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME Hyung Tak Oh | | | 15. MOTHER'S MAIDEN NAME Sung Ye Kim | | 9. BALTIMORE CITY OR COUNTY OF DEATH City |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-96-2055 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife |
| 17. INFORMANT In Ho Choe | | | ADDRESS 501 Stevenson Lane | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) GI Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic active hepatitis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
10 years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 Noon 5/24, 1982 , to 6:20 pm 5/24, 1982 , that (I) (we) last saw the deceased alive on 5/24, 1982 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Steven L. Joffe | | | | 22c. DATE SIGNED 5/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven L. Joffe | | | | 22e. ADDRESS U of Md. Hosp | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE May 26, '82 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery | |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | ADDRESS 8521 Loch Raven Blvd. | | 25a. DATE REC'D BY REGISTRAR MAY 26 1982 | |
| 25b. REGISTRAR'S SIGNATURE James J. Arthur | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 21a. - 21f. & 22a. STATE OF MARYLAND | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR File #G568 6-4-82 AL DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 1 9 1 7 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Ellwood Edward Clarke | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 14 82 | | 2b. HOUR 12 noon | |
| 3. SEX male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 7 27 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman, - Locke | | 12b. KIND OF BUSINESS OR INDUSTRY Insulator Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE md. | | 13b. COUNTY A.A. Co | | 13c. CITY OR TOWN Balt. | | 13e. STREET ADDRESS 3721 Brooklyn Ave | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Philip - Clark | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Elizabeth Martin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-09-2322 | | 17. INFORMANT ADDRESS Mr. Ellwood D. Clarke, Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
9509 IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) acidosis
DUE TO, OR AS A CONSEQUENCE OF (c) LYSOL ingestion + probable pulmonary aspiration | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
~48 hours
~48 hours | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Probable chronic obstructive pulmonary disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR - AM MONTH DAY YEAR 10:21 a.m. 5 12 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Pt. drank Lysol | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Baltimore | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 12 , 19 82 , to May 14 , 19 82 , that (I) (we) lost saw the deceased alive on May 14 , 19 82 , that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. Signed | | | | | | | | | |
| 22b. SIGNATURE Barbara A. Fretwell | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED May 14 - 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara A. Fretwell | | | | 22e. ADDRESS S. Baltimore General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 18, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME McCutty Funeral Home, 237 E. Patapsco Ave. Balto. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 1 8

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lillian L. Clayton | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 7, 1982 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
April 1, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
city | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5610 Loch Raven Blvd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5610 Loch Raven Blvd. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James David Hessebauer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Staham | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
217-46-2189 | | 17. INFORMANT ADDRESS
Mr. William D. Clayton Jr. 305 Quaker Ridge Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) A.S.C.D.
DUE TO, OR AS A CONSEQUENCE OF
(c) Poisoning | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9-24 , 19 81 , to 1-5 , 19 82 , that (we) last saw the deceased alive on 1-5 , 19 82 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frank S. Palmisano MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-8-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frank S. Palmisano MD. | | | | 22e. ADDRESS
5122 Harford Road Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
May 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Warren | | | |

MEDICAL CERTIFICATION

unofficially registered

4.2.24

Polonium



Polonium

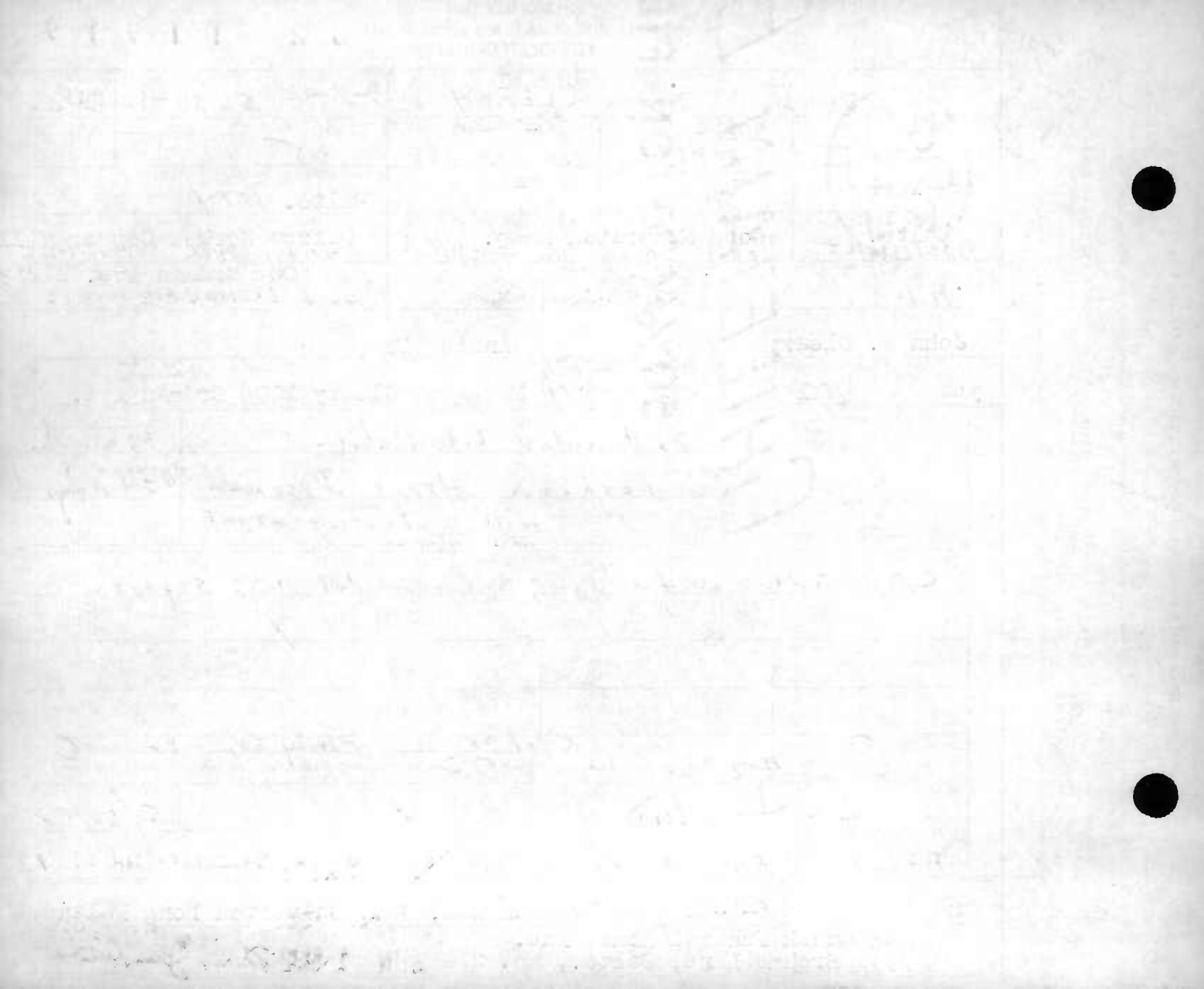
W.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 9 1 9
REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
EDGAR B. CLEARY | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-30-82 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
10-10-96 | | 2b. HOUR
5:30 M | |
| 6. AGE
85 YRS. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto CITY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
New York | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Good Samaritan Hosp. | | 12a. USUAL OCCUPATION (TYPE OR PRINT)
Office Worker | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Copper Mill | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS
4006 Erdman Ave. | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John F. Cleary | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annie Fox | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. (IF YES, GIVE WAR OR DATES)
WWI | |
| 17. INFORMANT
Margaret Cleary | | 18. ADDRESS
4006 Erdman Ave. | | 19. CITY OR TOWN
Baltimore | | 20. STATE
Md. | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
DUE TO, OR AS A CONSEQUENCE OF (b) ischemic HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) WITH CONGESTIVE HEART FAILURE | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 minutes
approximately 24 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
C.O.P.D.; renal failure; subendocardial M.I.; Sepsis. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16/82 19 82 , to May 30, 19 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on May 30, 19 82 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lx Tan | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FELIX TAN, M.D. | | 22e. ADDRESS
3808 ERDMAN AVE, BALTIMORE, Md. 21213 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6-4-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Calverton Nat. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Calverton Long Island, New York | |
| 24. FUNERAL DIRECTOR (NAME)
Schimunek Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE
John Tan | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 9 2 0 | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ARTHUR Cobb | | | | 2a. DATE OF DEATH MONTH 5 / DAY 9 / YEAR 82 2b. HOUR 1200 PM | | | |
| 3. SEX Male | | 4. RACE W | | 5. DATE OF BIRTH MONTH 2 DAY 24 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Millwright | | 12b. KIND OF BUSINESS OR INDUSTRY Steel | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST James MIDDLE Cobb LAST Goltha | | 15. MOTHER'S MAIDEN NAME FIRST Byars MIDDLE Byars LAST Byars | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO. 241-16-3661 | | 17. INFORMANT ADDRESS Mrs. Barbara Cobb, 6306 Brown Avenue, Baltimore, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4254 } DUE TO, OR AS A CONSEQUENCE OF (b) Idiopathic Myocardopathy } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 5/5 , 19 82 , to 5/9 , 19 82 , that (I) (we) lost saw the deceased alive on 5/9 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Lawrence J. Appl | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence J. Appl | | 22e. ADDRESS Baltimore City Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-12-82 | | 23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Baltimore STATE Md. | |
| 24. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Avenue, Baltimore, Md. | | | | 25a. RECEIVED BY REGISTRAR MAY 11 1982 REGISTRAR'S SIGNATURE Nicholas T. Matthews | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified. Once notified, the medical examiner must be present at the funeral home for the purpose of examining the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 9 2 1 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
Lucille R Coffey | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 31 1982 | | 2b. HOUR
M | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
Nov. 16 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Emmett Montgomery | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lula Mae Fuller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
227-03-5089 | | 17 INFORMANT ADDRESS
Lela M El Mahdi 467 Severnside Dr., Park Severna | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4360 IMMEDIATE CAUSE (a). <u>Cerebral accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(b). <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c).
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> 19 <u>50</u> to <u>5/31</u> 19 <u>82</u> , that (I) <u>did</u> did not see the deceased alive on <u>5/31</u> 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Conrad L. Richter</u> M.D. | | | | 22c. DEGREE
M.D. | | 22d. DATE SIGNED
6/1/82 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Conrad L. Richter | | | | 22f. ADDRESS
3128 Harford Rd Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24 FUNERAL DIRECTOR
NAME
A. Alan Seitz Funeral Home | | | | 25a. BY REGISTRAR
1502 | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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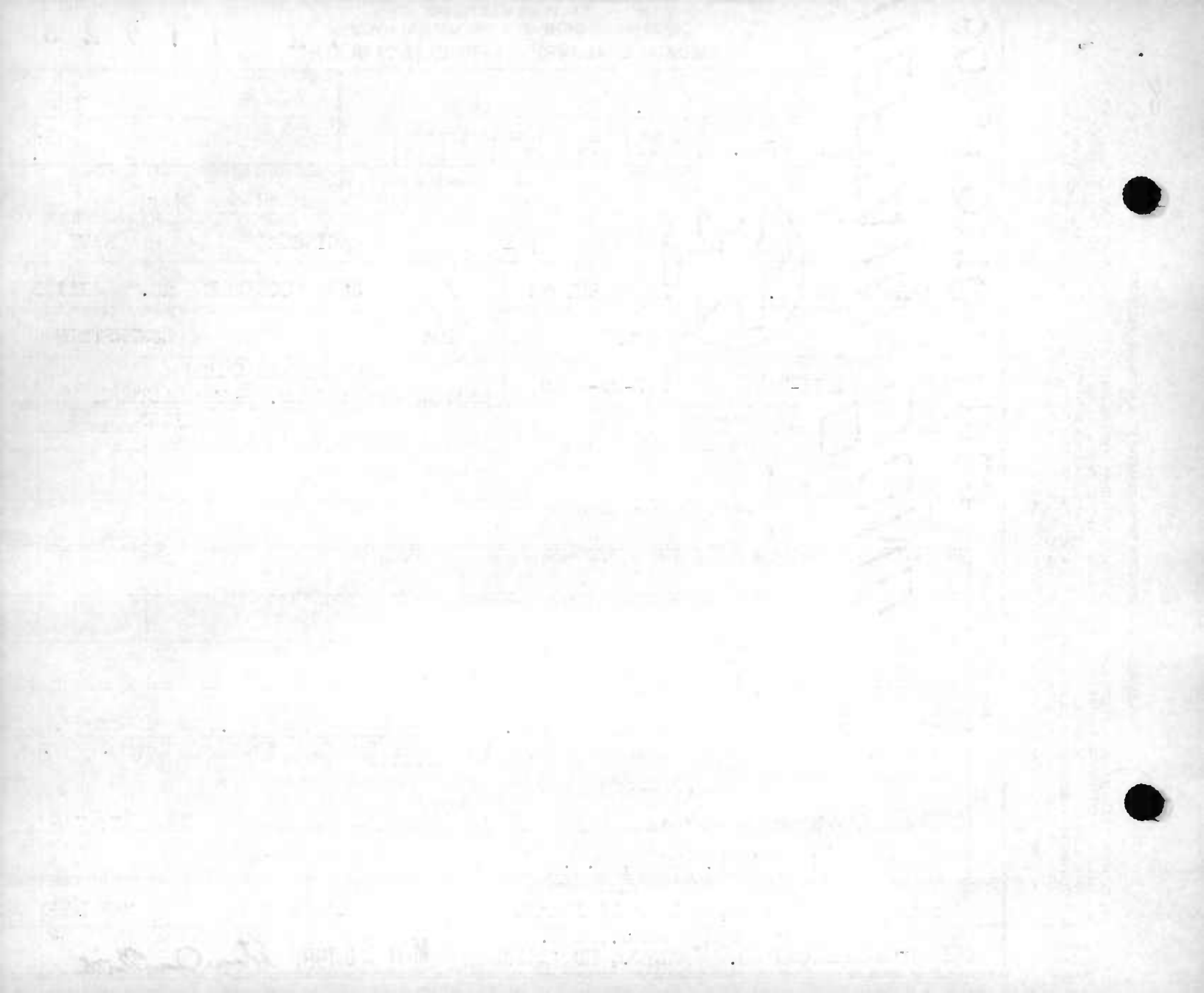
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 2 2
REG. NO. | | | |
|---|--|--|--|---|--------------|---|--|--|---------------------|---------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
LEONARD | MIDDLE
H. | LAST
COHAN | 2a. DATE OF DEATH
MONTH DAY YEAR
5 22 82 | | 2b. HOUR
5:50 PM | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4100 N. Charles St. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
President | | 12b. KIND OF BUSINESS OR INDUSTRY
Paint Co. | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4100 N. Charles St. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sidney B. Carter | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie Hecht | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-09-3402 | | 17. INFORMANT
ADDRESS
Mrs. Celeste Cohan 4100 N. Charles St.
Balto., Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
1890
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Primary Carcinoma Left Kidney
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Oct. 1980 | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1945, 19, to May 22, 1982, that (I) (we) lost saw the deceased alive on May 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Louis PHAMBURGER JR. | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/27/82 | | | | | |
| 22d. PHYSICIAN'S NAME
(TYPE OR PRINT) | | 22e. ADDRESS
PO Box 5709 BALTIMORE Md. 21208 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
5/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 7 1982 | | 25b. REGISTRAR'S SIGNATURE | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 1 9 2 3 | |
|--|-------------------------|--|---|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Sidney B. Cohen | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 5 DAY 25 YEAR 1982 | | 2b. HOUR 3:55 a. M | | | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH FEB. DAY 2 YEAR 1912 | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
MONTH 5 DAY 25 YEAR 1982 | | 2d. HOUR 3:55 a. M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital - STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
NAVY | | | |
| 13a. STATE
MARYLAND | | 13b. CITY OR TOWN
BALTO. | | 13c. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13d. STREET ADDRESS
8604 WOODSPRING RD. #21133 | | | | | |
| 14. FATHER'S NAME
FIRST ALBERT MIDDLE COHEN LAST COHEN | | | | 15. MOTHER'S MAIDEN NAME
FIRST IDA MIDDLE LOWENSTEIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
577-05-8629 | | 17. INFORMANT
MISS MINNIE COHEN
8604 WOODSPRING RD. RANDALLSTOWN, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Complications of blunt injuries to legs & head
8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____ | | | | | | | | | | 21133 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR 7:30 P.M. MONTH 4 DAY 7 YEAR 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
pedestrian struck by auto | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET Rt. 26 east of Brenbrook Rd., CITY OR TOWN Randallstown, COUNTY Balto., STATE Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY)
Assistant M.D. | | | | DATE SIGNED 5-25-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAY 26, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
BNAI ISRAEL | | | | 23d. LOCATION
CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 28 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Shane Jan North</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 2 4 | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1 - FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
ELSA M. COLEBERG | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 18 82 | | 2b. HOUR
10 40 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 11 39 | | 6. AGE (IN YEARS LAST BIRTHDAY)
43 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 15. KIND OF BUSINESS OR INDUSTRY
--- | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY CAROLINE 13c. CITY OR TOWN PRESTON | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
P.O. BOX 57 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CARL L. COLEBERG | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JEANNETTE L. HANDLEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-36-7015 | | 17. INFORMANT HARRINGTON, ADDRESS DELAWARE 19952
L. DONALD McKNATT (F.H.) 50 COMMERCE ST. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
4300 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>subarachnoid hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ruptured aneurysm</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 16. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> 19 <u>82</u> , to <u>6/18</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Mark Carol</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/18/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Carol | | | | | | 22e. ADDRESS
UMD Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
REMOVAL/BURIAL | | 23b. DATE
05-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLLYWOOD CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
HARRINGTON KENT DELAWARE | | | | | |
| 24. FUNERAL DIRECTOR
NAME BALTO., MD. ADDRESS 21229
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 21 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> | | | | | |

MEDICAL CERTIFICATION

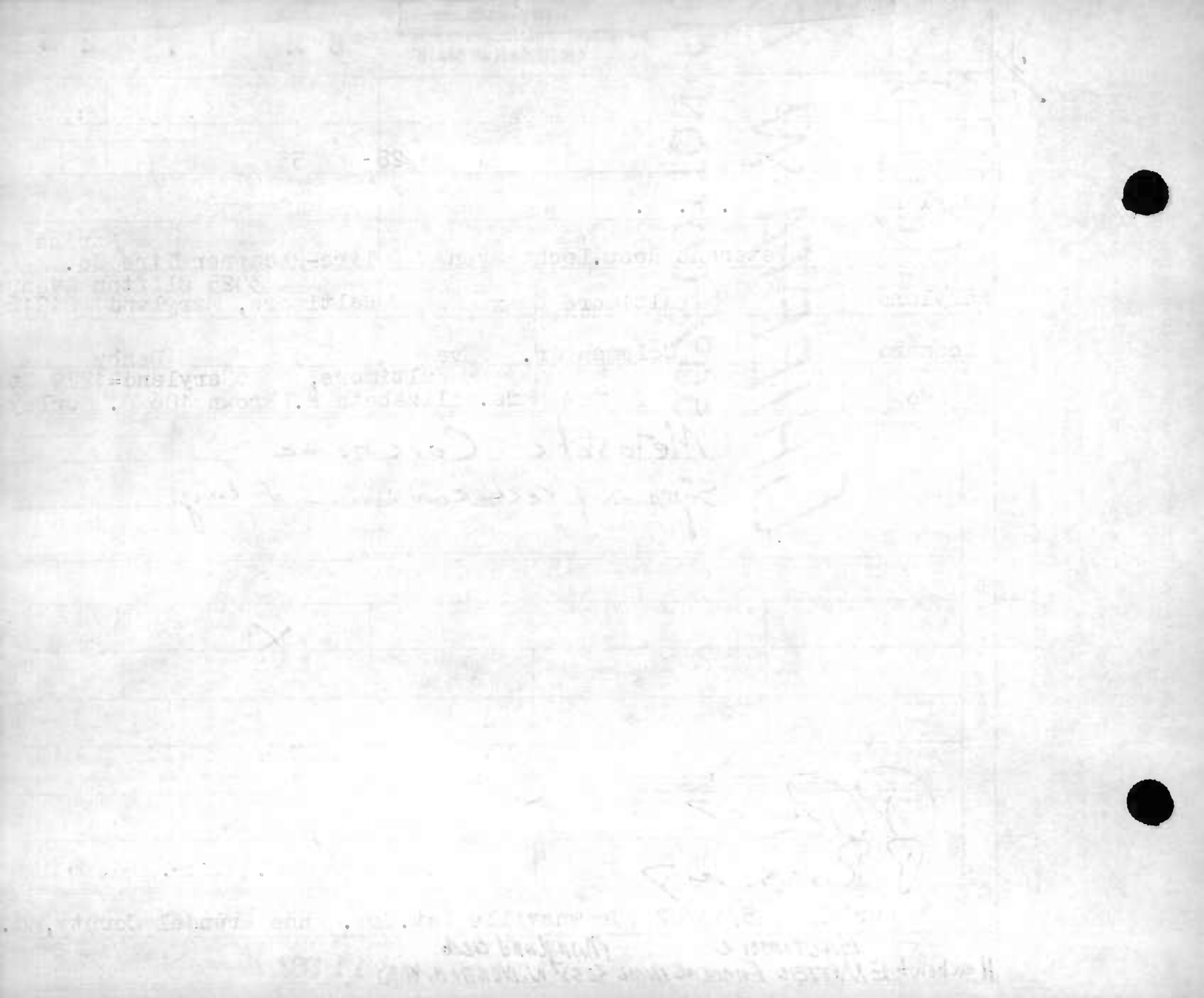
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

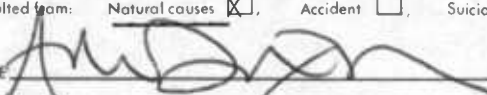
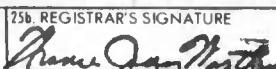
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--------------------------|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 1 9 2 5 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| LEONARD COLEMAN | | | | | 5 8 82 6:00A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | BLACK | | 11 10 1928 | | 53 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U. S. A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | Veterans Hosp. Loch Raven | | | | Tire-Recapper | | Tire Co. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | | | |
| Maryland | | | | Baltimore | | 3025 Clifton Avenue Baltimore, Maryland 21216 | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| Leonard Coleman Jr. | | | | | Eva Denby | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| No | | | | | 214 20 5254 | | Baltimore, Maryland 21229 St Mrs. Elizabeth F. Brown 106 S. Morley | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Metastatic Carcinoma | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Squamous Cell Carcinoma of Lung | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 21g. I certify that (this hospital) attended the deceased from APRIL 13, 19 82, to MAY 8, 19 82, that (we) lost (we) the deceased alive on MAY 8, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (we) (we) view the body after death. | | | | | | | | | |
| 22. SIGNATURE DEGREE | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | |
| 3900 Loch Raven Blvd. Balto., Md. 21218 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| 23b. DATE | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | |
| 25. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
15M 2/80

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11926 | |
|--|--|------------------|--|---|---|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM R. COLEMAN | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
5 16 1982 | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 9 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
5 16 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GA | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
935 N. Broadway | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
935 N. Broadway | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sandy Coleman | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alberta Marshall | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-01-0479 | | 17. INFORMANT ADDRESS
Carrie Hilson 2920 Poplar Terrace | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Seizure disorder</u>
7803
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 5-17-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H ADDRESS
1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

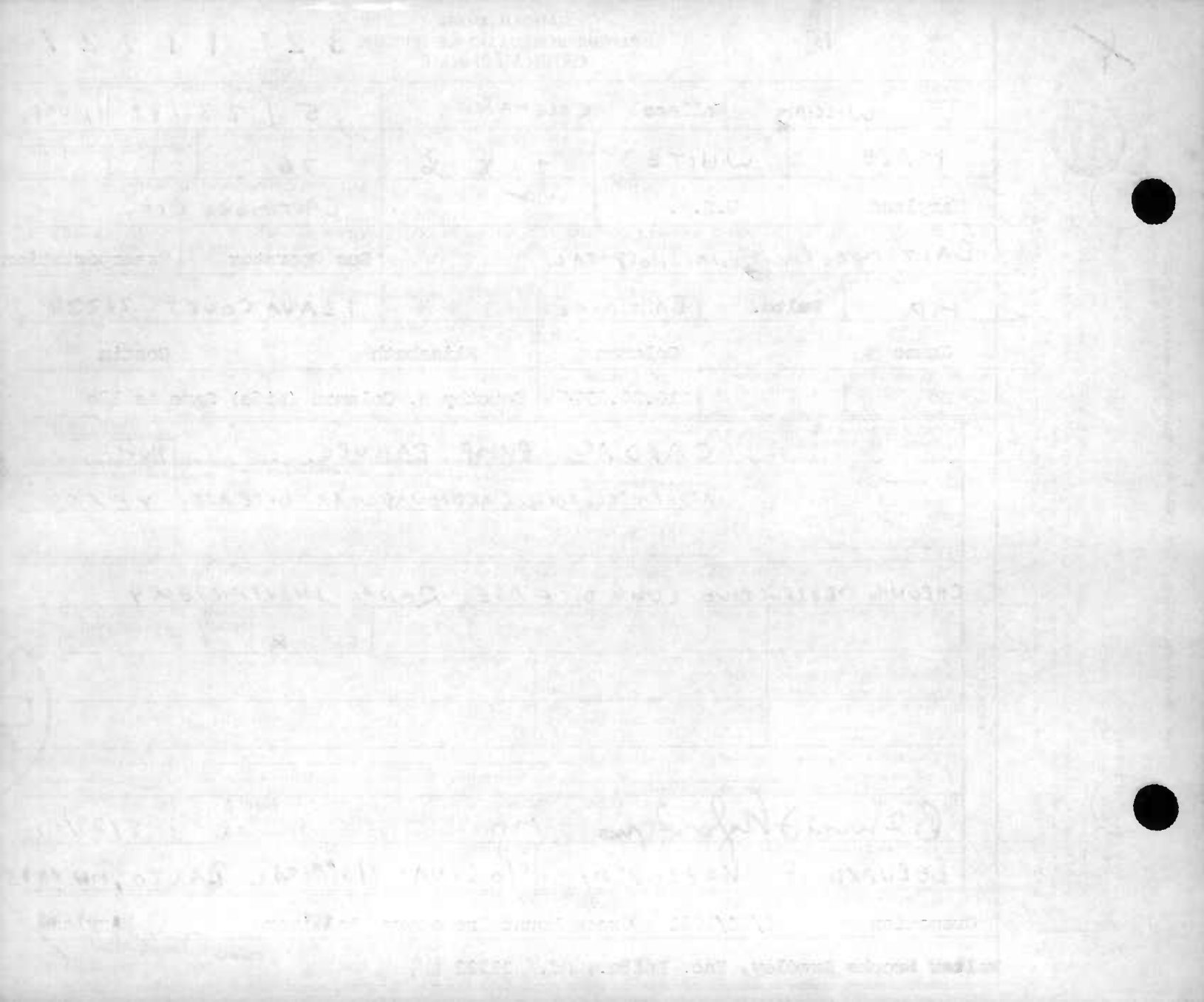
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 2 7 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM Wallace COLEMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 / 23 / 82 | | | |
| 3. SEX
MALE | | | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 8 06 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bus Operator | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Transportation | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1 LAVA COURT 21234 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
James Coleman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Costin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216.20.8776 | | 17. INFORMANT ADDRESS
Dorothy W. Coleman (Wife) Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4292 CARDIAC PUMP FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c)
CONDITIONS, IF ANY, WHICH
GAVE RISE TO IMMEDIATE
CAUSE (a), STATING THE
UNDERLYING CAUSE LAST | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
HOURS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CHRONIC OBSTRUCTIVE LUNG DISEASE, RENAL INSUFFICIENCY | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bernard F. Kozlovsky | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARD F. KOZLOVSKY | | 22e. ADDRESS
S/O SINAI HOSPITAL, BALTO., MD. 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
5/24/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley, Inc. Balto., Md. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 26 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, but for notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|--------------------------------------|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 1 9 2 8
REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Katherine Coles | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 18, 1982 | | | | | 2b. HOUR
9:40 PM |
| 3. SEX
Female | | 4. RACE
Col | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 18, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
124 W. Franklin St | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Anthony | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Cherry | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
220-12-7295 | | 16c. INFORMANT
Mr. Charles R. Lee | | ADDRESS
93 Elylane Va. Petersburg |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
4442
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Pulmonary Emboli, Renal Failure, Cerebrovascular Accident | | | | | | | | | | |
| 19a. DATE OF OPERATION
May 15, 1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Thrombo-emboli in left femoral artery | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 10, 1982, to May 18, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on May 18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Donald Kerr M.D. | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/19/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald Kerr, M.D. | | | | 22e. ADDRESS
C/O Maryland General Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ | | | | ADDRESS
2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1982 | | 25b. REGISTRAR'S SIGNATURE
Thane J. Martin | | |

MEDICAL CERTIFICATION

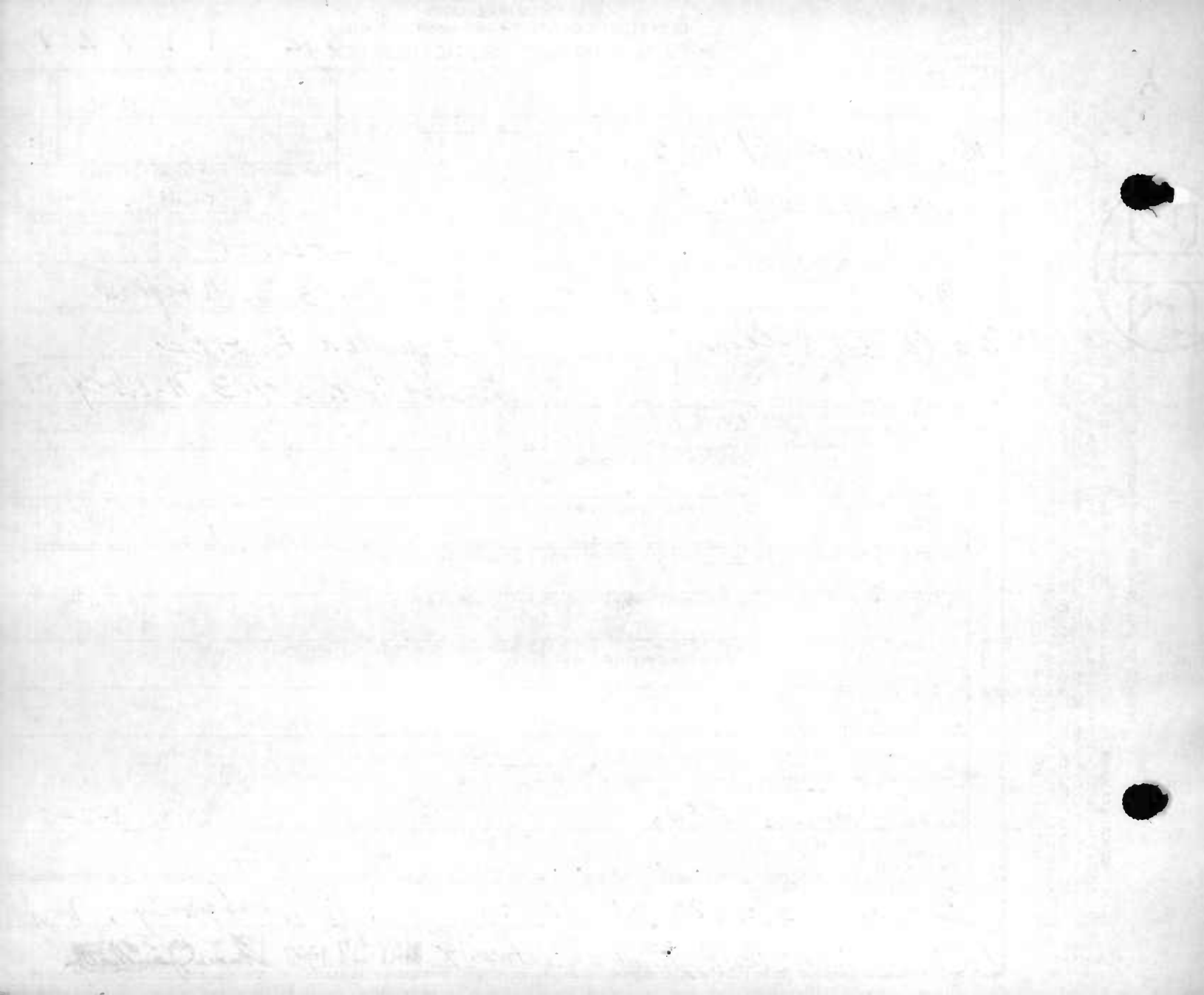
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8211929 | | | |
|--|--|------------------|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Earl Collins | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> MONTH DAY YEAR
5 24 1982 | | 2b. HOUR
M | |
| 3. SEX
M. | | 4. RACE
NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR
9/11/27 | | 6. AGE (IN YEARS) LAST BIRTHDAY
54 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
5 24 1982 | | 7d. HOUR
4:30 P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
413 N. Wolfe Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
413 N. Wolfe St | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Wm. (Matt) Collins | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Priscilla Brooks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS
Priscilla Collins 413 N. Wolfe St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cirrhosis of the Liver</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
5-25-82 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore City, Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Locks FUNERAL Home | | | | ADDRESS
1304 N. Central | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1987 | | 25b. REGISTRAR'S SIGNATURE
Thane J. [Signature] | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

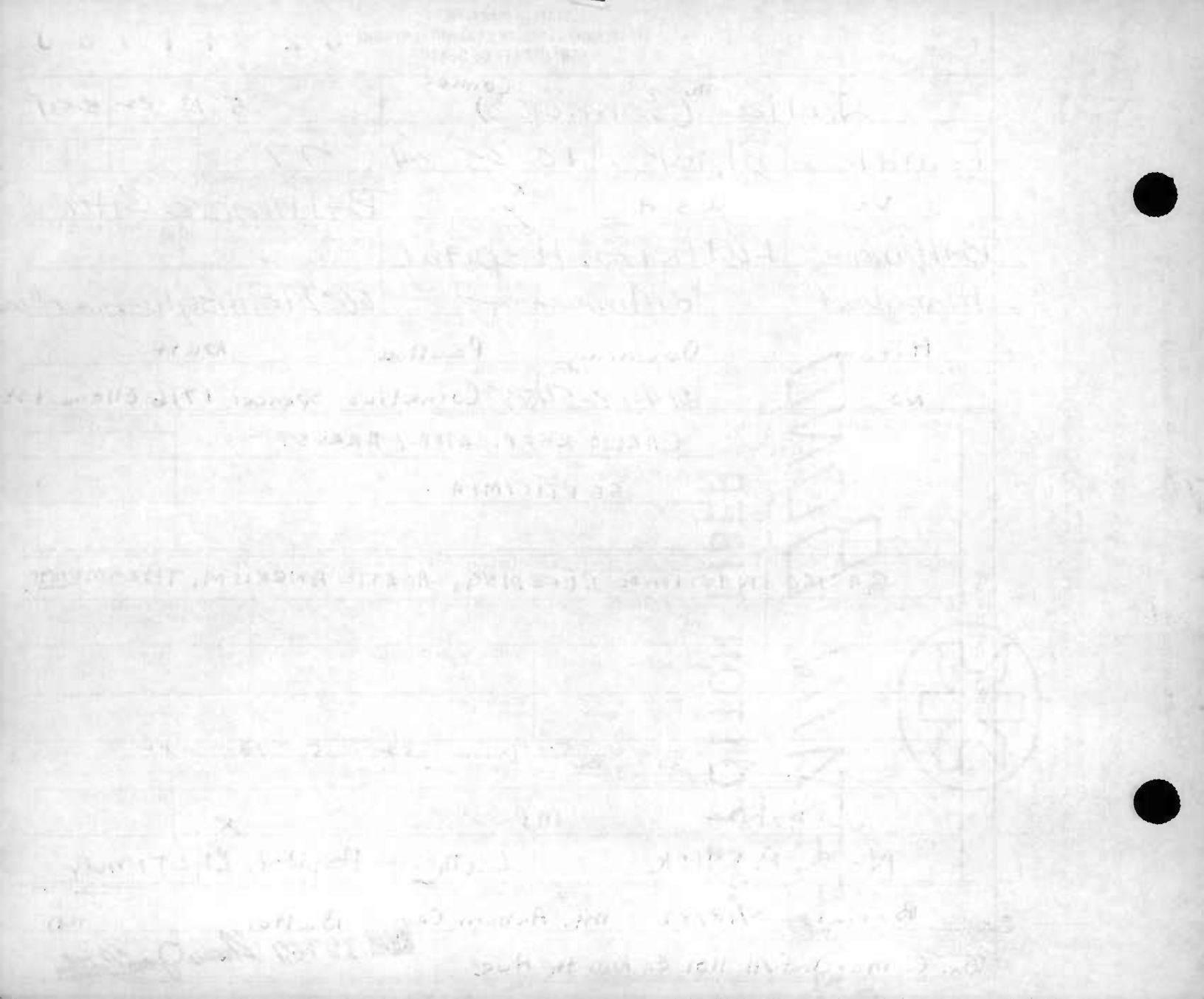
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REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| FOR
1- STATE
REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 5 13 82 | | 5:53 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Black | | 10 05 04 | | 77 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Va. | | U.S.A. | | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Baltimore | | Lutheran Hospital | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Maryland | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 607 Pennsylvania Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Hiram Downing | | Pauline Nutt | | NO | | 214-18-5488 | |
| 17. INFORMANT | | ADDRESS | | 17a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
0389
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>SEPTICEMIA</u>
(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Cornelius Spencer | | 1716 Ellamont St | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>GASTRO INTESTINAL BLEEDING, AORTIC ANEURISM, THROMBOSIS.</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-11-82</u> , to <u>5-13-82</u> , that (I) (we) last saw the deceased alive on <u>5-13-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE
<u>N. S. ASHOK</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| | | Lutheran Hospital, Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 5/18/82 | | Mt. Auburn Cem. | | Balto. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE OF REGISTRATION | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 1101 E. North Ave. | | MAY 19 1982 | | <u>Theresa J. [Signature]</u> | | | |

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 3 1 | |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| Herman F. Cook, Jr. | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
HERMAN F COOK JR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 7 82 | | 2b. HOUR
5 40 P M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
7 30 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIO OF MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
CASKETS |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. CITY OR TOWN BALTO | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERMAN F COOK SR | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MABEL GAUSS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)
YES WW II | | 16b. SOCIAL SECURITY NO
213-05-3689 | | 17. INFORMANT
Katharine C. Cook-Baltimore, MD. 21237 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5789 HYPOTENSION
DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) GI BLEEDING
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
SMALL CELL LUNG CANCER | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/4 19 82, to 5/7 19 82, that (I) (we) last saw the deceased alive on 5/4 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward J. Lee MD | | DEGREE
MD | | 22c. DATE SIGNED
5/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD J. LEE | | 22e. ADDRESS
22 S Greene St BALTO, MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 11, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery Baltimore City | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | 24. FUNERAL DIRECTOR
LARRY M. & RUSSELL C. WITZKE Funeral Homes P.A.
1630 Edmondson Ave. Catonsville, Maryland 21228 | | | |
| 24a. DATE REC'D. BY REGISTRAR
MAY 11 1982 | | 24b. REGISTRAR'S SIGNATURE
Frances Jan Nathan | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 7. REG. NO.
8 667399 9 3 2 | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 21 1982 | | 2b. HOUR
0:55A.M. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MAXINE H. COOK | | | | 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 27 1936 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Ca. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
BALTO. | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
37 STRAW HAT RD. 21117 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LINSON H. HALL | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERNICE PURSLEY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
466-55-6471 | | 17. INFORMANT
DAVID D. COOK | | ADDRESS
(SAME) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of Ovary</u>
1830
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <u>(a) this hospital</u> attended the deceased from <u>5/19</u> , 19 <u>82</u> , to <u>5/21</u> , 19 <u>82</u> , that <u>(1) (we)</u> lost
saw the deceased alive on <u>5/20</u> , 19 <u>82</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated
above, (1) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>P. T. PHAM</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/21/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. T. PHAM M.D. | | 22e. ADDRESS
SINAI HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANK H. NEWELL, INC | | | | ADDRESS
Pikesville, MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 3 3 | | | |
|---|--|---|--|---|--|---|--|
| FOR
1. STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Miniam E Cooper | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 12 82 | | 2b. HOUR
10 AM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 12 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Luskins | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Porunan | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Candlyn Holland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-30-625 | | 17. INFORMANT
ADDRESS
David Cooper - 704 W. Carey St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory + Cardiac Arrest</u>
5188
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Stroke, acute</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pulmonary Emboli and/or Pneumonia</u> | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
DAYS
weeks
Months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>2-15-1982</u> to <u>5-12-1982</u> , that (I) (we) lost
saw the deceased alive on <u>5-11-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
DEGREE
William R. Law MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5-12-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM R. LAW MD | | | | 22e. ADDRESS
200 W. BALTIMORE ST
BALTO. MD 21223 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn C. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City MD | |
| 24. FUNERAL DIRECTOR
NAME
E. Curle | | | | 24a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 24b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

60-1-1

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1990

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 3 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|---|--|---|---------------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN J CORCORAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/26/1982 | | 2b. HOUR
5:59
A.M. | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASION. | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 12 1910 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
72 YRS. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
IRELAND. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GENERAL HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SERVICE MAN | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN J CORCORAN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY GUILFOYLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
011-01-4712 | | 17. INFORMANT
ADDRESS
JEAN CORCORAN 217 S. CHESTER | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4960 SEVERE CHRONIC obstructive pulmonary Disease**
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

Arteriosclerotic Heart Disease

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16/82 to 5/26/82 , that (I) (we) lost
saw the deceased alive on 5/26/82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Marcos B. Galicia Jr., MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCOS B. GALICIA JR MD | | 22e. ADDRESS
North Charles Gen. Hosp. | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JOHN M. WEBER & SONS INC. CHESTER | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Theresa J. Smith</i> | |

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1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | YEAR | | 2b. HOUR | |
| Miriam Beatrice Corre | | | | | | | | 5/20/82 | | 5 | | 20 | | 12 ¹⁰ PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | Caucasian | | Aug. 24, 1903 | | | | 78 | | | | YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Illinois | | USA | | | | | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 6511 Parsons Avenue 21207 | | | | | | Housewife | | | | Home | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | --- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6511 Parsons Avenue 21207 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| August | | Bessie | | Haber | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| No | | 340-09-8367 | | 2021 W. Rogers Ave. Mr. Paul J. Booth Baltimore, Md. 21209 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto myocardial Infarction</u> | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | | | | 8 years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>May 20, 1982</u> to <u>May 20, 1982</u> , that (I) (we) lost <u>to</u> the deceased <u>above</u> , (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | | | | | 22c. DATE SIGNED | | | |
| <u>Manuel Leiva MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | <u>5/20/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | |
| <u>MANUEL LEIVA MD</u> | | <u>6001 PK HOTS AVE BALTO MD 21215</u> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| Cremation | | 5/21/82 | | Security Process | | | | Catonsville Baltimore, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| MacNabb Funeral Home | | Catonsville, Md. | | | | | | | | | | <u>MAY 24 1982</u> <u>Thomas J. MacNabb</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours following death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 5 #G568 6/10/82 ph

FOR 7a,8
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 3 6

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Henry A Cosby | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 30 82 | | | 2b. HOUR
10 ¹⁰ PM | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 2 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Cosby | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES AND OR BIRTHDAY) NO | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Malcolm Cosby 2322 W Mosher St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER of Esophagus
1509
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
WRITE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 30 19 82, to MAY 30 19 82, that (I) (we) lost
saw the deceased alive on MAY 30 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John A. Cosby | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Cosby | | 22e. ADDRESS
Lutheran Hosp | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King PK | | 23d. LOCATION
BALTO., Md. COUNTY STATE | |
| 24. FUNERAL DIRECTOR
LEROY O. DYETT 4600 LIBERTY HTGS. AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 2 1982 | | 25b. REGISTRAR'S SIGNATURE | |

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 300-4545.

8-1 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 1 9 3 7
REG. NO.

| | | | | | | | | | | | |
|--|--|-------------------------|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Thomas E. Cosgrove Jr. | | | 2a. DATE OF DEATH
MONTH 5 DAY 24 YEAR 1982 | | | 2b. HOUR
8:42AM | | | | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 9 DAY 23 YEAR 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 12. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 13. CITY OR TOWN OF DEATH
Baltimore | | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | 15. 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chief Auditor | | | 16. 12b. KIND OF BUSINESS OR INDUSTRY
Md. P.S.C. | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto. | | | 18. 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 19. 13e. STREET ADDRESS
4812 Holder Ave.-21214 | | | | | |
| 14. FATHER'S NAME
FIRST Thomas E. MIDDLE Cosgrove LAST Sr. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Annie S. MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
220-05-5697 | | | 17. INFORMANT
ADDRESS
Virginia A. Cosgrove - 4812 Holder Ave.-21214 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiovascular Hunt
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5-27-82 | | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | | 23d. LOCATION
CITY OR TOWN Balto. Md. COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1982 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 3 8 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST
JULIA G. COURTNEY | | | | MONTH DAY YEAR
5 7 82 | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MONTH DAY YEAR
02 24 02 | | 7a. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE AND | | 12b. KIND OF BUSINESS OR INDUSTRY
BANKING | |
| 13a. STATE
MARYLAND | | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13c. CITY OR TOWN
ANNAPOLIS | | 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES GASSAWAY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BARBARA WOPPMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
286-07-7452 | | 17. INFORMANT ADDRESS
ANNAPOLIS, MD.
PATRICIA ANN KEMP 101 KINGSWOOD ROAD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS, unknown source
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Raymond Flores MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND FLORES MD | | | | 22e. ADDRESS
Luthean Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
REMOVAL/BURIAL | | 23b. DATE
05-10-82 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTLAWN MEM. GAR. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FT. LAUDERDALE BROWARD FLA. | |
| 24. FUNERAL DIRECTOR
NAME
BALTO., MD. | | | | 25a. DATE REC'D BY REGISTRAR
MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances S. [Signature] | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | | | |

1138

UNITED STATES DEPARTMENT OF THE INTERIOR

OFFICE OF THE SECRETARY OF THE INTERIOR

WASHINGTON, D. C.

DEPARTMENT OF THE INTERIOR

UNITED STATES DEPARTMENT OF THE INTERIOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 9 3 9
REG. NO. | | | | |
|--|--|---|--|---|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Marion H. Cowman | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 6, 1982 | | | | 2b. HOUR
3:00a M |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 23, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Banking |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John G. Herman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella May Anthony | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
216 01 0873 | | 17. INFORMANT ADDRESS
Wesley Home, Inc. Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1930
IMMEDIATE CAUSE (a) Papillary Carcinoma of Thyroid
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Bilateral Pneumonias | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 7 , 19 82 , to May 6 , 19 82 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on May 6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
John R. Bartholomew M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
5/6/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John R. Bartholomew, M.D. | | | | 22e. ADDRESS
C/O Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8 May 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
Burgess Funeral Home, 3631 Falls Rd. 21211 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 7 1982 | | 25b. REGISTRAR'S SIGNATURE
Francis J. Nathan | | |

May 6, 1962 13:00

Continued

B.

Nation

Female

White

July 27, 1902

79

England

U.S.A.

x

Baltimore City

Baltimore

Naval General Hospital

Secretary

Banking

Baltimore

Baltimore

x

2211 N. Moore Avenue

John G. Herman

Miss Mary Anthony

216 01 0693 Wesley Home, Inc. Care

Spillars & Sons of Texas

Bilateral Pneumonitis

May 6

John H. Baltimore, B.U.

Unreal

May 1962

Baltimore, Maryland

Wesley Home, 2021 N. 2211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3a. DATE OF BIRTH | | 3b. AGE (IN YEARS LAST BIRTHDAY) | |
| FIRST MIDDLE LAST
Arthur M. Cox | | MONTH DAY YEAR
Jan. 21, 1917 | | YRS MONTHS DAYS
65 | |
| 2. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1132 Washington Blvd. Balto. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Stationary Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
Joseph W. Cox | | FIRST MIDDLE LAST
Emma Medford | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
215-10-9327 | | 17. INFORMANT
Mr. Joseph A. Cox, 1366 Washington Blvd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
2500 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD
(c) Diabetes mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
COPD, ↑BP | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1981 to April 1982, that (I) (we) last saw the deceased alive on MAY 10 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bruce A. Blumenthal MD | | 22c. DATE SIGNED
5/13/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B Blumenthal MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | 23e. COUNTY
Maryland | | 23f. STATE | |
| 24. FUNERAL DIRECTOR
NAME
McGully Funeral Home, 130 E. Fort Ave. Balto. Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |



| No. | Date | Locality | Collector | Remarks |
|-----|------|----------|-----------|---------|
| 1 | 1905 | ... | ... | ... |
| 2 | ... | ... | ... | ... |
| 3 | ... | ... | ... | ... |
| 4 | ... | ... | ... | ... |
| 5 | ... | ... | ... | ... |
| 6 | ... | ... | ... | ... |
| 7 | ... | ... | ... | ... |
| 8 | ... | ... | ... | ... |
| 9 | ... | ... | ... | ... |
| 10 | ... | ... | ... | ... |
| 11 | ... | ... | ... | ... |
| 12 | ... | ... | ... | ... |
| 13 | ... | ... | ... | ... |
| 14 | ... | ... | ... | ... |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 15a-e per phone 5/19/82 and state of MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 8 2 1 1 9 4 1

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST (Baby Boy) Glenn LAST CRADDOCK

2a. DATE OF DEATH MONTH DAY YEAR 4 26 82 2b. HOUR P 10:25 M

3. SEX Male 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR 4 24 82

6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN. 1

9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 9b. CITIZEN OF WHAT COUNTRY? U.S.A. 10. MARRIED ☐ NEVER MARRIED ☒ 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD. 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 4400 Plainfield Ave. 21206

14. FATHER'S NAME FIRST MIDDLE LAST Glenn CRADDOCK 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Denise Hartley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT Parents/chart ADDRESS Sinai Hosp.

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hyperkalemia & bradycardia 3 days
7701 } DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure 45 days
{ DUE TO, OR AS A CONSEQUENCE OF (c) Meconium Aspiration & Group B Strep Sepsis 5 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Probable DIC 2° to sepsis

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/21 19 82 to 4/26 19 82, that (I) (we) last saw the deceased alive on 4/26 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.

22b. SIGNATURE Jody Lanard DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED 4/26/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT) JODY LANARD 22e. ADDRESS Sinai Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE MAY 1, 1982 23c. NAME OF CEMETERY OR CREMATORY Arbunus Mem Park 23d. LOCATION CITY OR TOWN COUNTY STATE ARBUNUS PARK M.D.

24. FUNERAL DIRECTOR NAME ADDRESS Redd Funeral Home 5209 YORK Rd. BALTO. MD. 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 25b. REGISTRAR'S SIGNATURE

12-1-11 11-1-11 10-1-11 9-1-11 8-1-11 7-1-11 6-1-11 5-1-11 4-1-11 3-1-11 2-1-11 1-1-11

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12-1-11 11-1-11 10-1-11 9-1-11 8-1-11 7-1-11 6-1-11 5-1-11 4-1-11 3-1-11 2-1-11 1-1-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

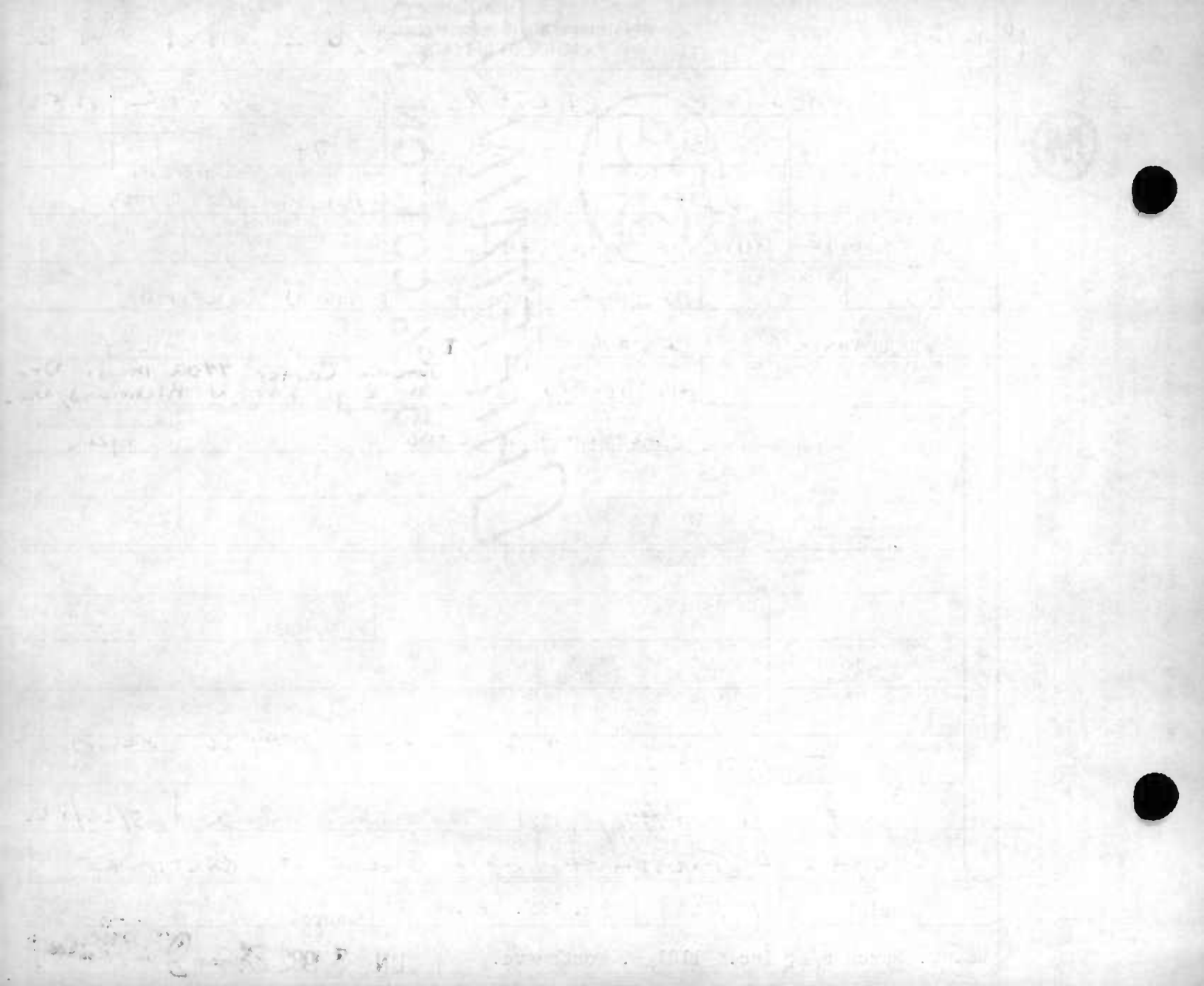
IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be called to certify.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 4 2

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) JAMES E. CARTER | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 26 82 | | | 2b. HOUR
10 P M | | | |
| 3 SEX
m | | 4 RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 29 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD | | 13b. COUNTY
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1106 N. DUKELAND | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM A. CARTER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDITH M. BAILEY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-03-7386 | | 17 INFORMANT Jerome Carter ADDRESS 9402 maji Dr.
PREVIOUS REGISTRATION Richmond, Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | |
| PART 2: OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from MAY 24 19 82 , to MAY 26 19 82 , that (I) (we) last saw the deceased alive on MAY 26 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 21g. SIGNATURE
Cynthia A. Forsthoft, MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CYNTHIA A. FORSTHOFT | | | | 22e. ADDRESS
22 S. GREENE ST., BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. NAT. MEM. PK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurel MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H, Inc. | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. H. H. H. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 4 3 | | | | |
|--|--|--|--|---|--|--|--|--|
| FOR
1. STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
(Margaret) Elvera m. Cash | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
5 12 82 150 AM | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 23 37 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
City Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charlie B. Cash | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Viola Lomax | | 13e. STREET ADDRESS
110 Willow Ct. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Viola Cash 101 Center Place | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) <u>Cardiopulmonary collapse</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic breast cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>82</u> , to <u>5/12</u> , 19 <u>82</u> , that (I) (we) lost <u>the deceased alive on 5/12, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>5/12/82</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Lloyd Stahl</u> | | 22e. ADDRESS
<u>Baltimore City Hospital</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>5/17/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Cem.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore MD</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Wm. C. March F/H 1101 E. North Ave</u> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>MAY 14 1982 [Signature]</u> | | | | |

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

English

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 4 4 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| Paul Calvin Copenhaver | | | | 5 28 82 8:15 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | |
| MALE | | CAUCASIAN | | 4 26 99 | | 83 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Pennsylvania | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | UNIVERSITY OF MARYLAND HOSPITAL | | BALTIMORE | | freight rates dept.-compiler RAILROAD | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | Carroll | | NEW WINDSOR | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Anson | | Emma Mutschler | | | | | |
| 17. INFORMANT | | ADDRESS | | 17. INFORMANT | | ADDRESS | |
| T. COPENHAVER | | 120 CHURCH ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | minutes | | | |
| IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST | | | | | | | |
| 0381 | | | | DAYS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) SINGLE OCCASION SEIZURES | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| NONE | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 5/10/82, 19, to 5/28, 19, that (we) lost | | | | | | | |
| saw the deceased alive on 5/28, 19, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Eric Tannenbaum, MD | | | | | | 5/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| ERIC TANNENBAUM | | | | 22 S. GREENE ST. | | | |
| | | | | UNIV. OF MARYLAND HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. NAME OF REGISTRAR | |
| Burial | | 5/30/82 | | Winters Cemetery | | near New Windsor Carroll, Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE OF REGISTRATION | | 25b. REGISTRAR'S SIGNATURE | |
| D. A. Shupler New Windsor, Md. | | | | JUN 3 1982 | | | |

BP

Paul Calvin Coppenaver

Pennsylvania U.S.A.

Private letter
Dept.-commission

Control
T. Anson
Woods

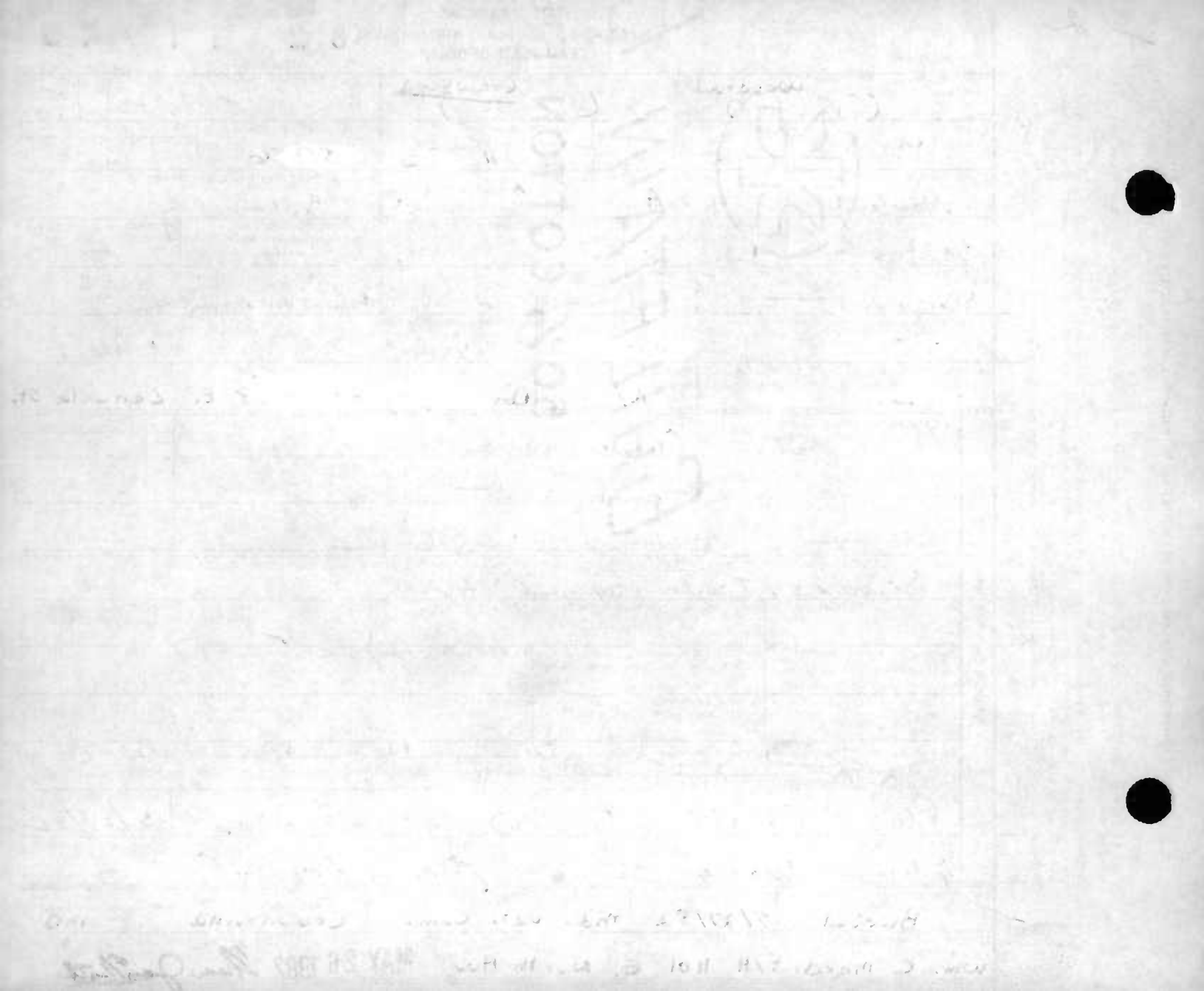
Butler W30182 Antares Company New England Control Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 4 5 | | | |
|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<u>Woodrow</u> <u>Crawford</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>5</u> <u>25</u> <u>82</u> | | | |
| 3. SEX
<u>M</u> | | 4. RACE
<u>B</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>2</u> <u>11</u> <u>26</u> | | 2b. HOUR
<u>1 05</u> AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U. S. A</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
<u>56</u> YRS. | | 8. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Mercy Hospital</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | 17a. KIND OF BUSINESS OR INDUSTRY | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 17b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<u>Maryland</u> | | | | 13b. CITY OR TOWN
<u>Baltimore</u> | | 13c. STREET ADDRESS
<u>Federal Hill Nursing Home</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Kattie</u> <u>Li Hae</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>yes</u> | | 16b. SOCIAL SECURITY NO.
<u>N/A</u> | | 17. INFORMANT ADDRESS
<u>Dorothy Phillip</u> <u>1408 E. Lanvale St.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>4860</u> DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Respiratory arrest</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Pneumonia, Lung Cancer</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Seizures, Tracheoesophageal fistula</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I (this hospital) attended the deceased from <u>5/1</u> , 19 <u>82</u> , to <u>5/25</u> , 19 <u>82</u> , that (I/we) last saw the deceased alive on <u>5/25</u> , 19 <u>82</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Edward C. Watters III</u> | | | | DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>5/25/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Edward C. Watters III</u> | | | | 22e. ADDRESS
<u>Mercy Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>5/27/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>md. Vet. Cemo.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>Crownsville</u> <u>MD</u> | |
| 24. FUNERAL DIRECTOR NAME
<u>Wm. C. March F/H 1101 E. North Ave.</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>MAY 26 1982</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Ann J. Smith</u> | |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 4 6

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
LEE G. CREAGER | | 2a. DATE OF DEATH MONTH DAY YEAR
5 5 82 | | 2b. HOUR
11P M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
6 22 38 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
43 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5915 Walther Ave 21206 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Service Tec. | 12b. KIND OF BUSINESS OR INDUSTRY
Sears |
| 13a. STATE
Maryland | | 13b. COUNTY
- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William S. CREAGER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
AUDREY DENTON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
219 26 7911 | | 17. INFORMANT ADDRESS
Margaret L. Creager - 5915 Walther Ave. - 21206 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, endocarditis
2041
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic lymphocytic leukemia
DUE TO, OR AS A CONSEQUENCE OF (c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 82 , to 5-5 , 19 82 , that (I) (we) lost saw the deceased alive on 5-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Nancy Nichols MD | | DEGREE
MD | | 22c. DATE SIGNED
5/6/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Nancy Nichols M.D. | | 22e. ADDRESS
Union Memorial Hospital - B'more, 21218 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | 23b. DATE
5-7-82 | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto. Md. |
| 24. FUNERAL DIRECTOR NAME
John C. Miller Inc-6415 Belair Rd.-21206 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAY 11 1982 [Signature] | | |

U.S. DEPARTMENT OF THE INTERIOR

Geological Survey

Washington, D.C.

June 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,

John W. Powell

Chief of Division

Division of Geology

U.S. Geological Survey

Washington, D.C.

Enclosed for you are two copies of a report on the geology of the

vicinity of the mouth of the Colorado River, by J. W. Powell.

I am, Sir, very respectfully,
Your obedient servant,

John W. Powell

Chief of Division

Division of Geology



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1-81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 9 4 7
REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} <u>Raymond</u> ^{MIDDLE} <u>Harold</u> ^{LAST} <u>Crockett</u> | | | | 20. <u>5/24/82</u> | | | |
| 2. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>2/9/49</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore, Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore City Hospitals</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Disabled</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>1121 Rayleigh Way 21224</u> | |
| 14. FATHER'S NAME ^{FIRST} <u>Ernest</u> ^{MIDDLE} <u>Lee</u> ^{LAST} <u>Crockett</u> | | | | 15. MOTHER'S MAIDEN NAME ^{FIRST} <u>Ollie (Olive)</u> ^{MIDDLE} <u>Beatrice</u> ^{LAST} <u>Parks</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>216-12-8949</u> | | 17. INFORMANT ADDRESS <u>Ernest E. Crockett 1615 Four Georges Ct.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> 4100
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> , 19 <u>82</u> , to <u>5/24</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>M. Welinsky</u> DEGREE <u>M.D.</u> | | | | 22c. DATE SIGNED <u>5/24/82</u> | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Welinsky</u> | | | | 22f. ADDRESS <u>Balt. City Hosp's</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | 23b. DATE <u>5-27-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Westview Crematorium</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Westview, Balto. Co. Md.</u> | |
| 24. FUNERAL DIRECTOR (NAME) <u>C.S. Zeiler & Son Inc.</u> ADDRESS <u>6224 Eastern Avenue</u> | | | | 25a. DATE RECD. BY REGISTRAR <u>MAY 25 1982</u> REGISTRAR'S SIGNATURE <u>James J. Nathan</u> | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11948 | |
|--|--|------------------|--|--|--|--|--|---|------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 20. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
LUTHER Ralph CRUSHONG | | | | | | | | | | 20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
5-30-82 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8 9 02 79 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
79 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
5-30-82 | | 21. HOUR
5:38 | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
repair man | | 12b. KIND OF BUSINESS OR INDUSTRY
cement co. | |
| 13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Carroll | | 13c. CITY OR TOWN
Union Bridge | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
57 Hoff Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Abram | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Catherine Dayhoff | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
215-09-0317 | | | | 17. INFORMANT
Catherine Crushong Union Bridge, Md | | | | 17. INFORMANT ADDRESS
57 Hoff Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
<u>9190</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY MONTH DAY YEAR
12:00 noon 5-19-82 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject was riding a lawn mower and was run over by it. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
57 Hoff Rd. Union Bridge, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | | | TITLE (SPECIFY)
M.D. Assistant | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | | | ADDRESS
111 Penn Street | | | DATE SIGNED
5-30-82 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Grace U.C.C. Cemetery Taneytown | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Carroll Md. | |
| 24. FUNERAL DIRECTOR NAME
L. D. Shickler | | | | | | ADDRESS
Union Bridge, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |

Height

White 5' 8" 120

Weight 150

Married

27 Holt Rd.

Union Bridge

Barrett

Married

Catherine Barrett

Wife

Catherine

Wife

27 Holt Rd.

215-09-2317 Catherine Barrett Union Bridge, Md.

Wife

Wife

215-09-2317 Catherine Barrett Union Bridge, Md.

Wife

Wife

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 18a. Film #G568 6-4-82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 1 9 4 9
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|------------------------------------|--|--|
| FOR STATE AL REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Kathleen Cummings | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR HOUR
5 11 82 2²⁰ AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 11 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospo | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6602 EBERLE DR., APT. 301 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE BASHER | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VIRGINIA CLENDENIN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
236 745733 | | 17. INFORMANT
MRS. LUCILLE SAWYER
6506 EBERLE DR., APT. 101 BALTO., MD 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular arrhythmia
4100
DUE TO, OR AS A CONSEQUENCE OF 1-acute M.I. 2-necrotizing bronchopneumonia
(b) 3-non-occlusive ischemic colitis with lower intestinal hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/5 19 82 to 5/11 19 82 , that (I) (we) last saw the deceased alive on 5/11 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Claudio Levin | | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/11/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CLAUDIO LEVIN | | | | | 22e. ADDRESS
Sinai Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAY 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FT. MYERS VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

UNITED STATES

RECEIVED

RECEIVED

RELEASED ON APPROVAL DR KORELL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/B1
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 1 9 5 0 | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|---------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) BRUCE WAYNE CURRY | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 26, 1892 | | 2b. HOUR
11:45p | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/5/73 | | 6. AGE (IN YEARS LAST BIRTHDAY)
9 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(COUNTRY)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
ELKRIDGE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
5730 ELKRIDGE HTS. RD | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LYNN CURRY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE MONTGOMERY | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
FATHER | | ADDRESS
ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4939 IMMEDIATE CAUSE (a) ASTHMA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 HOURS | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1980 , to MAY 1982 , that (I) (we) last saw the deceased alive on MAY 16, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Stephen J. Mose DEGREE | | | | | | | | 22c. DATE SIGNED
MAY 28, 1982 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN J. MOSE MD | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY
EAK LAWN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
J.E. CONNELLY ADDRESS
300 MACE | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 2 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | | | | | |

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130
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JAN 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO: J. E. CARROLL, JR. (100-100000-100000)
FROM: J. E. CARROLL, JR. (100-100000-100000)
SUBJECT: [Illegible]
DATE: 1/10/64
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 5 1

REG. NO.

| | | | | | | |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CLARA REBECCA DAEHNKE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05 01 82 | | 2b. HOUR
235 AM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
5 29 99 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
82 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Helwig | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-18-0270 | | 17. INFORMANT ADDRESS
Albert H. Daehnke 2611 Washington Blvd. 21230 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c) right cerebral infarction
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/17/82 to 5/1/82 , that (I) (we) lost saw the deceased alive on 4/30/82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Jerry D. Skarbek M.D. | | | | 22c. DATE SIGNED
5/1/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jerry D. Skarbek M.D. | | | | 22e. ADDRESS
St. Agnes Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAY 3 1982 | | | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | | |

MEDICAL CERTIFICATION

35
10
35
300
1
2
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "DEPARTMENT OF" are faintly visible.]

UNITED STATES
DEPARTMENT OF
COMMERCE
BUREAU OF
MANUFACTURES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 5 2 | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| FLOYD DANIELS | | | | 5/9/82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| MALE | | NEGRO | | JUNE 27 1910 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| NORTH CAROLINA | | U.S.A. | | 71 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE | | UNION MEMORIAL | | BALTIMORE CITY MD | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | | | BALTIMORE | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13d. STREET ADDRESS | |
| WILLIAM STARKIE DANIELS | | LILLIE SIMMONS | | 2416 BRENTWOOD AVE. 21218 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 228-14-6941 | | SALLIE M DANIELS/2416 BRENTWOOD AV | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebrovascular accident</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>malnutrition, dehydration</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>malnutrition, dehydration</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| N/A | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOME <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>5/7/82</u> to <u>5/9/82</u> , that (I) <u>was</u> last saw the deceased alive on <u>5/9/82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>not</u> <u>viewed</u> did not view the body after death.) | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Dana E. King MD</u> | | | | 5/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| <u>Dana E. King</u> | | <u>Union Memorial Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 05/13/82 | | KING MEMORIAL PARK | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| MARSHALL W JONES, JR/4101 | | MAY 11 1982 | | <u>James Van Kesteren</u> | |

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI (100-374211)
FROM : SAC, NEW YORK (100-108888) (P)
SUBJECT: [Illegible]

RE: NEW YORK TELETYPE TO BUREAU, JUNE 27, 1964.
[Illegible]

NEW YORK OFFICE ADVISED THAT [Illegible]
[Illegible]

IT IS REQUESTED THAT YOU [Illegible]
[Illegible]

VERY TRULY YOURS,
[Illegible]

ENCLOSURE
[Illegible]

ADMINISTRATIVE
[Illegible]

100-374211-108888
[Illegible]

100-374211-108888
[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| Lillie B. Daniels | | 5 30 82 | |
| 3. SEX | | 2b. HOUR | |
| Female | | 9 ⁵⁵ AM | |
| 4. RACE | | 5. DATE OF BIRTH | |
| Black | | 11 28 1898 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Balto., Md. | | 83 | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| USA | | Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | |
| Balto. | | Good Samaritan Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| | | | |
| 13a. STATE | | 13b. COUNTY | |
| Md. | | | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| William Riley | | Janie Griffin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| No | | | |
| 17. INFORMANT | | ADDRESS | |
| Austin Daniels | | 4424 Marble Hall Rd. Apt. 366 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> | | | |
| 4291 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC MYOCARDIAL DISEASE</u> | | 1977 | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROSIS (GROSSLY EVIDENT)</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | |
| | | P.M. 19 | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | 21f. LOCATION | |
| | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 1977, to <u>May 29</u> , 1982, that (I) (we) last saw the deceased alive on <u>5/30</u> , 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | |
| <u>Gilbert L. Banfield M.D.</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| Gilbert L. Banfield M.D. | | 722 N. Fulton Ave 21117 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Burial | | 6/4/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| ARBUTUS MEM. PK. | | BALTO., MD. COUNTY STATE | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | |
| NAME LEROY O. DYETT 4600 LIBERTY HGTS AVE. | | 25b. REGISTRAR'S SIGNATURE | |
| | | JUN 2 1982 | |

MEDICAL CERTIFICATION

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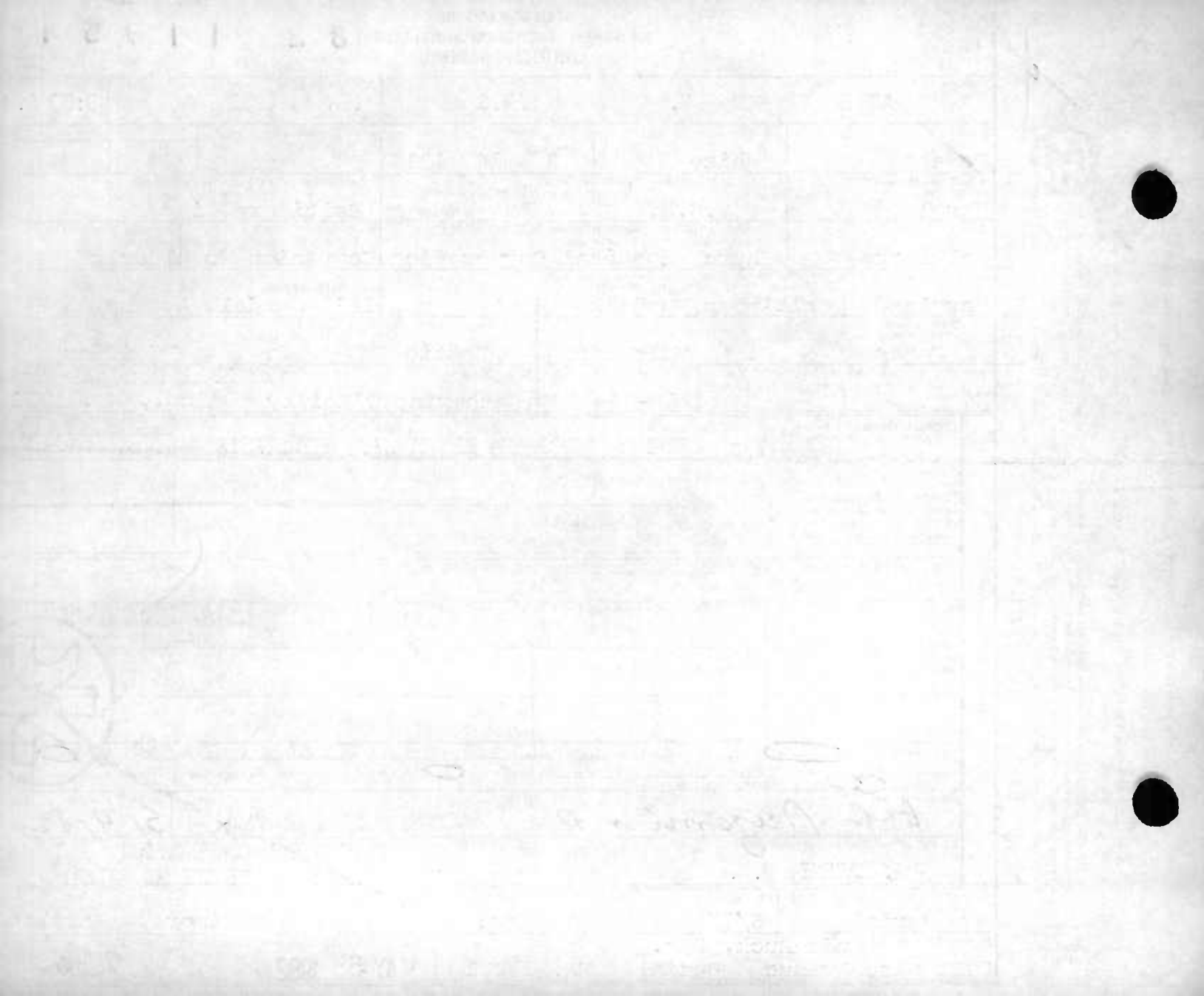
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 5 4 | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | M | | | | | |
| AGNES V. DAVIS | | | | MAY 4, 1982 | | | | 9:50 A.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | MONTH DAY YEAR
3 14 1916 | | 66 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Church Hospital Corporation | | | | Companion To Elderly | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| | | | | Maryland | | Baltimore | | Dundalk | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1811 Dundalk Avenue | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| James H. Valentine | | | | Kattie C. Pfeiffer | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | | | 216-36-3299 | | Katherine O'Kelley Balto., MD. | | 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1890</u> <u>TERMINAL CARCINOMA KIDNEY WITH METASTASIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>APRIL 30</u> , 19 <u>82</u> , to <u>MAY 4</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>MAY 4</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (If we did not view the body after death, so state.) | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <u>A. R. Nazemi M.D.</u> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | <u>5/4/82</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| A. NAZEMI, M.D. | | | | CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY, BALTIMORE MD 21231 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 5/7/1982 | | Oak Lawn | | Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Duda-Ruck, Inc.
7922 Wise Avenue Dundalk, MD. 21222 | | | | MAY 5 1982 | | | | <u>Frances Jan Kathan</u> | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 AE (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | |
|--|--|----------------|---------------|---|--|---|--|---|-------------------|---|--|---|--|---|-------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
JOHN | | | MIDDLE
A. | | | LAST
DAVIS SR. | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
5 24 1982 | | | 2b. HOUR
M
12:14 P
M | | | |
| 3. SEX
male | | 4. RACE
Col | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-3-1898 | | 6. AGE (IN YEARS
LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
5 24 1982 | | | 2d. HOUR
M
12:14 P
M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secour Hospital (DOA) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2537 Mc Henry St | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Taylor DAVIS | | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Alice Voney | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | | | | | | | |
| 16b. SOCIAL SECURITY NO.
212-05-3271 | | | | 16c. INFORMANT
ADDRESS
Mrs. Doralyn Sykes 4833 Denmore Ave | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon, M.D. | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED
5-24-82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. Co. Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ | | | | ADDRESS
2222 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1982 | | | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 1 9 5 6 | |
|--|--|---|--|--|--|
| JOHN E. DAVIS | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
John E Davis | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5/27/82 | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
1 17 1930 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wyman Park Health System | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS
906 GARDEN DRIVE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
RUSSELL R. DAVIS | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST
SUSIE MILLER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Army | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND IF UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
218-26-3433 | | 17. INFORMANT ADDRESS
VIOLET ZEPP 227 BYNUM RIDGE RD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation
4100
DUE TO, OR AS A CONSEQUENCE OF (b) Pacemaker insertion
DUE TO, OR AS A CONSEQUENCE OF (c) anterolateral myocardial infarction with arrhythmia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Diabetes mellitus, longstanding coronary artery disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
906-23 Garden Dr. Balto, MD | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 26, 1982 to May 27, 1982 , that (I) (we) last saw the deceased alive on May 27, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
C.S. Ramsey D.O. | | DEGREE
D.O. | | 22c. DATE SIGNED
5/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carol S. Ramsey D.O. | | 22e. ADDRESS
3100 Wyman Park Drive Balto, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
6/2/82 | | 23c. NAME OF CEMETERY OR INTERMENT
CROWNSVILLE VA | |
| 24. FUNERAL DIRECTOR NAME
John Coast | | ADDRESS
1211 Chesaco Ave. | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Anna J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 2 1 1 9 5 7 | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
JOSEPH (JOE) BRANTLEY DAVIS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 27 82 | | | | | 2b. HOUR
5:45 p.m. | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
10 11 19 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC BALTIMORE, MARYLAND 21218 | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
MD | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2613 E. Preston St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Brantley Davis Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Amanda Davis | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | | 16b. SOCIAL SECURITY NO.
256 10 9228 | | 17. INFORMANT ADDRESS
Lillie Mae Davis 2613 E. Preston St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>hypoxia</u>
1629 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>presumed lung cancer</u>
(c) <u>unknown</u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Chronic lung disease</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Dana E. King MD</u> | | | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/27/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D.E. KING | | | | | 22e. ADDRESS
3900 Loch Raven Blvd. Balto. Md. 21218 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
JUN 3 1982 <u>James Van Houten</u> | | | | | | | |

1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
8 2 1 1 9 5 8 | | | |
|---|--|---|--|---|---|--|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Leroy Davis | | | | | May 3, 1982 | | | | | | | M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
8 18 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
934 Stoddard Ct. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Henry Davis | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Queen Robinson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
249-10-1661 | | 17. INFORMANT ADDRESS
Maxine Davis 934 Stoddard Ct. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
myelofibrosis | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 19 79 to 5 19 82 that (I) (we) lost saw the deceased alive on 4 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Richard Ambinder | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/4/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard Ambinder | | | | 22e. ADDRESS
Johns Hopkins | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore | | 23e. DATE REC'D. BY REGISTRAR (DATE OF REGISTRATION)
MAY 5 1982 | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 working days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 5 9 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARTHA C. DAVIS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 10 82 | | 2b. HOUR
7:05P M | |
| 3. SEX
FEMALE | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
7 4 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13e. STREET ADDRESS
3408 DUVAL AVE
BALTIMORE, MARYLAND | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JAMES QUEEN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
SUSAN BRANFORD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-14-0994 D | | 17. INFORMANT City and State Address
Bryewood, Md. 21037
MRS MARTHA L PRANN 2503 Solomon's Island Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4360
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest
STROKE
DUE TO, OR AS A CONSEQUENCE OF (c)
Approximate interval between onset and death: 3 days | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/15, 19 82, to 5/16, 19 82, that (I) (we) last saw the deceased alive on 5/16, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Herbert K. Collision M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HERBERT K. COLLISION M.D. | | | | 22e. ADDRESS
PROVIDENT HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-14-82 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE CITY, MARYLAND | |
| 24. FUNERAL DIRECTOR NAME
BALTIMORE
HERBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 13 1982 | | 25b. REGISTRAR'S SIGNATURE
Ramon J. Norton | |

5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 6 0
REG. NO.

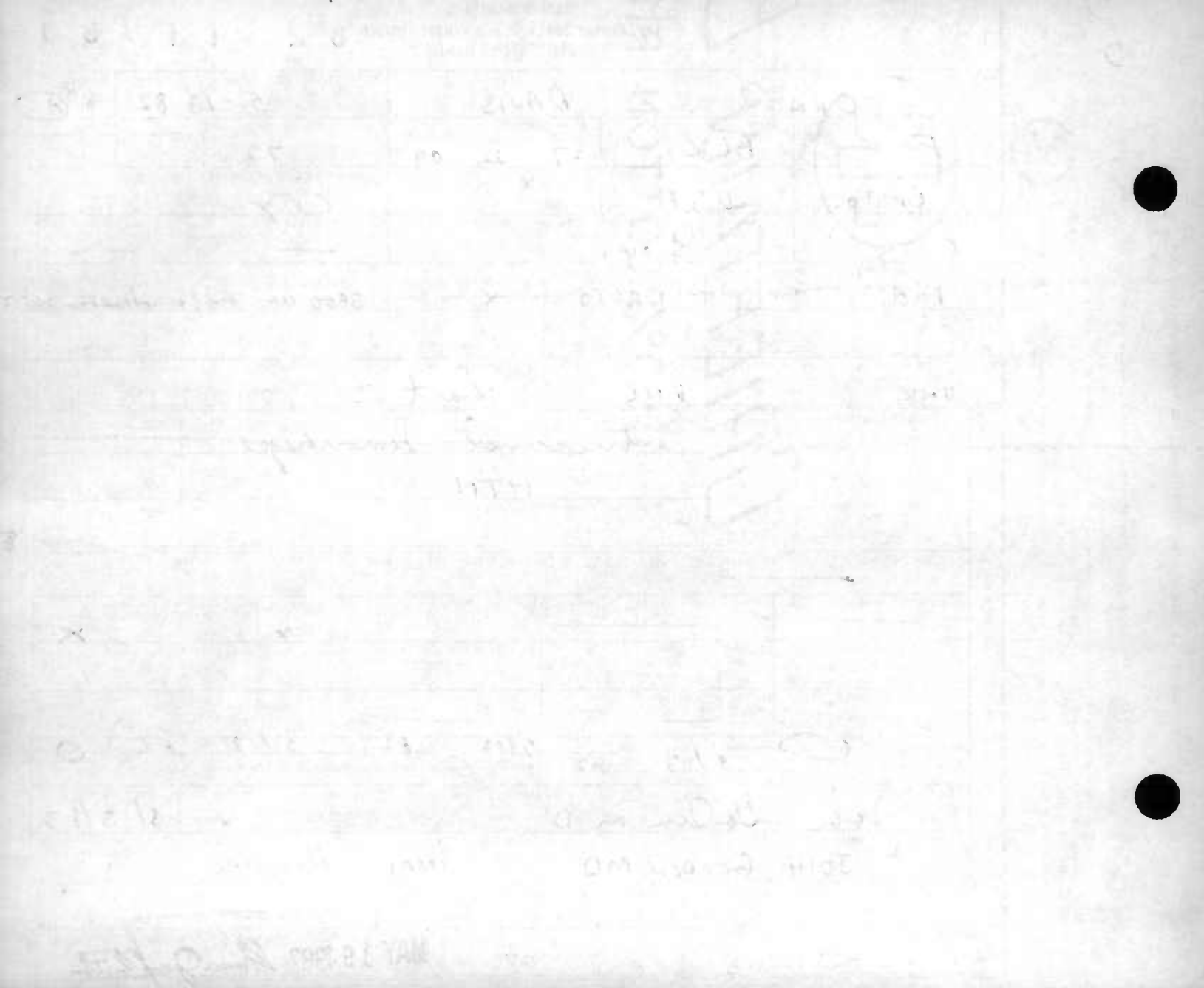
| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ORA D. DAVIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 13 82 | | 2b. HOUR
8 ⁴⁵ A.M. |
| 3. SEX
FEMALE | 4. RACE
BLK | 5. DATE OF BIRTH
MONTH DAY YEAR
3 21 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
BALTO. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE
13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3800 W. BELVEDERE #403 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALEXANDER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HESTER SMITH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNK | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
213-20-8429 | | 17. INFORMANT
ADDRESS
DOROTHY BOWMAN 2000 ODELL AVENUE | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>intracranial hemorrhage</u>
4329
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HTN</u>
(c) <u>17TN</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>5/12</u> 19 <u>82</u> , to <u>5/13</u> 19 <u>82</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>5/13</u> 19 <u>82</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John Gordon MD | | | | 22c. DATE SIGNED
5/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN GORDON MD | | | 22e. ADDRESS
SINAI Hospital | | |

| | | | |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
5/17/82 | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEM. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H 1101 E. NORTH AVE | | | 25. DATE REC'D. BY REGISTRAR 75b. REGISTRAR'S SIGNATURE
MAY 19 1982 [Signature] |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William W Day | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-14-82 | | | 2b. HOUR
6:00 P.M. | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 10 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
42 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City of Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dietary Technician | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Day | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Harris | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212149512 | | 17. INFORMANT
ADDRESS
Dorothy Day 623 Balco St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1550 Hepatoma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14/82 to 5/14/82 that (I) (we) lost saw the deceased alive on 5/14/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
KYAW NYUNT | | | | DEGREE | | 22c. DATE SIGNED
5/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
LUTHERAN HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-20-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Astonbury Church | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Severna Park MD | |
| 24. FUNERAL DIRECTOR
NAME
Thomas B. Blugger | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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29

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| 8 2 1 1 9 6 2
CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LARKIN H DELPH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 21, 1982 | | | 2b. HOUR
10:45 pm | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
4-7-1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 yrs. YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Anderson, Ind. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Church Hospital Corp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Printer | | 12b. KIND OF BUSINESS OR INDUSTRY
Printing | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Balto. Balto. | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Baltimore, Md.
30 Slavin Court 21236 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charlie Delph | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nettie Payne | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) WWII 266-18-2563 | | 17. INFORMANT ADDRESS
Balto., Md. 21236
Ann Delph, 30 Slavin Court, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC LUNG CARCINOMA
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (a) (the hospital) attended the deceased from MAY 14 19 82, to MAY 21 1982, that (I) (we) last saw the deceased alive on MAY 21 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
DAVID BOSE MD | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID BOSE MD | | 22c. DATE SIGNED | | | | 22d. ADDRESS
CHURCH HOME CORP.
100 N. BROADWAY BALTIMORE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Grove Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Tampa, Fla. 21231 | | 23e. DATE REC'D. BY REGISTRAR
MAY 25 1982 | |
| 24. FUNERAL DIRECTOR'S NAME
Schimunek Funeral Home, Inc.
9705 Belair Road, Balto., Md. | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR
MAY 25 1982 | | 24d. REGISTRAR'S SIGNATURE
Thomas J. Mather | | | |



NOTICE



X

MAY 22 1908

3

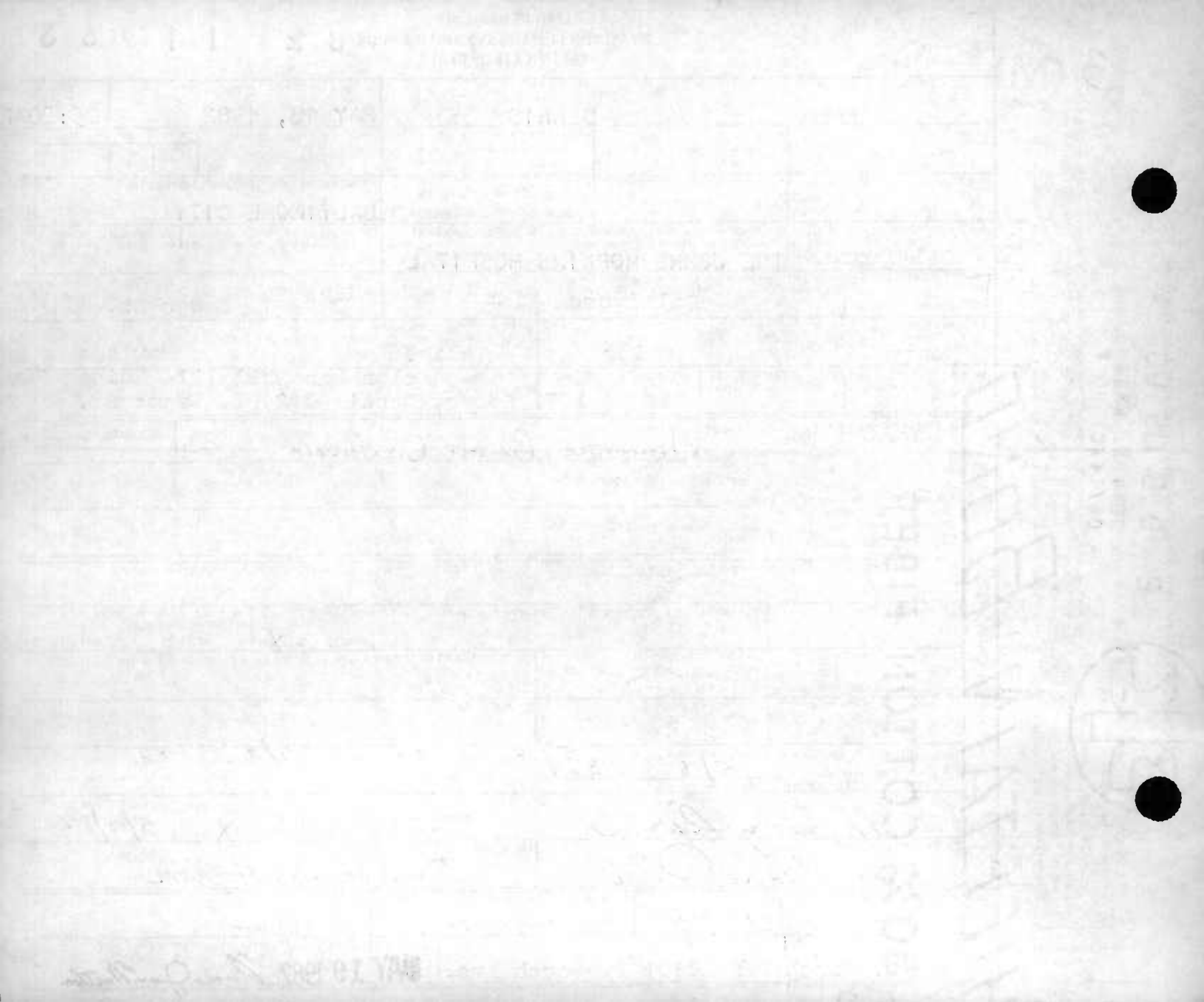
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that **DEATH** certificates be filed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 2 1 1 9 6 3 | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EMMA DENNIS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 18, 1982 | | | | | |
| 3 SEX
Female | | | | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 14 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2424 E. Eager St. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Coles | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Fowlkes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
214-14-1672 | | 17. INFORMANT Helen Marshall 1214 Edison Hwy
Robert Dennis 2424 E. Eager St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1749 Metastatic Breast Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/12 , 19 82 , to 5/18 , 19 82 , that (I) (we) lost saw the deceased alive on 5/18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>W. Bradley Pichro</i>
W. BRADLEY PICHRO | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5/18/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | |

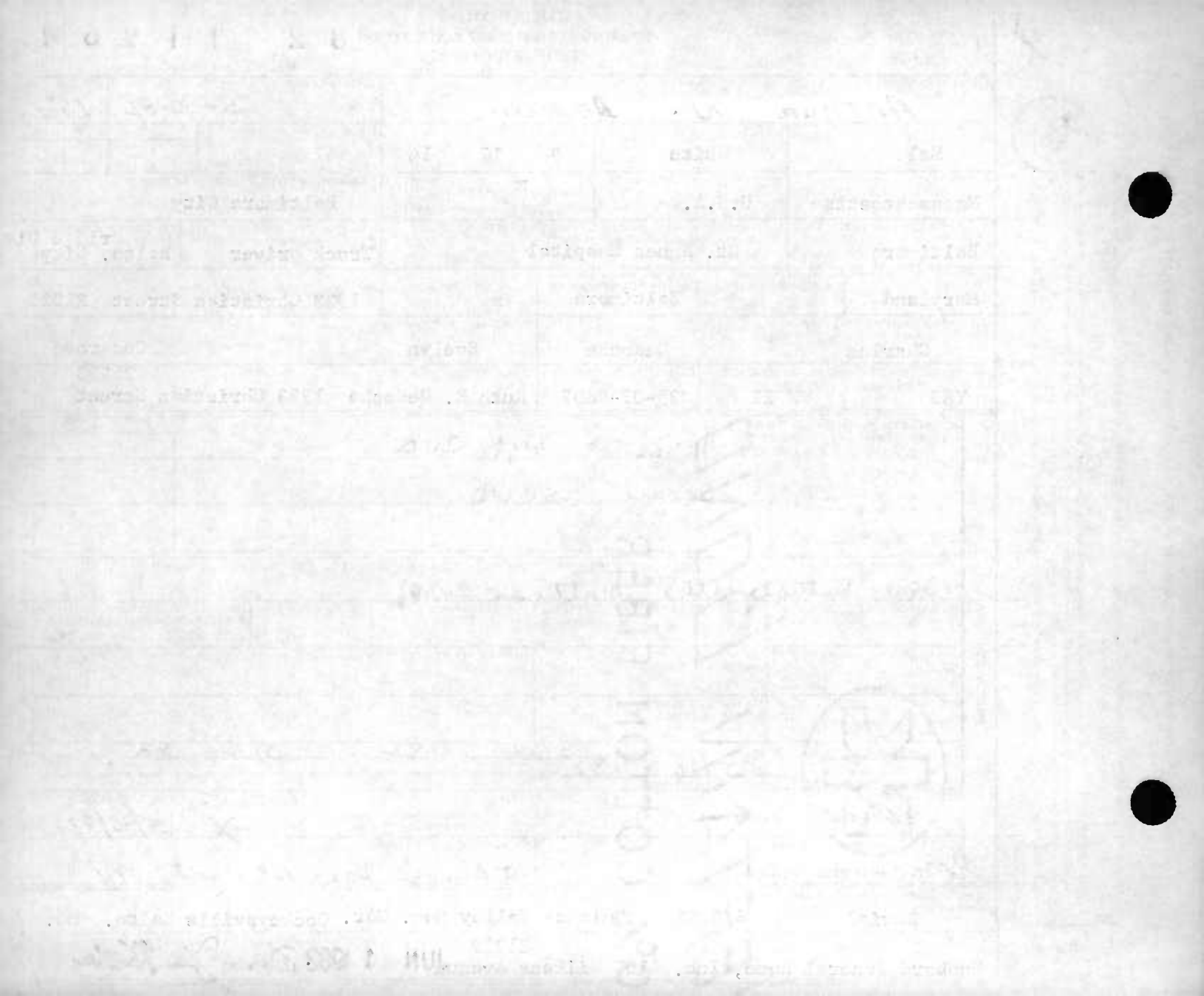


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 1 9 6 4 | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Arthur N. DeRoche | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-30-82 | | | | 2b. HOUR
1:45 AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
9 17 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 | | IF UNDER 1 YEAR MONTHS DAYS
YRS. | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Bridge Div Balto. City | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1933 Christian Street 21223 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles DeRoche | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Evelyn Cosgrove | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT
Ruth R. DeRoche | | ADDRESS
1933 Christian Street 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Left CVA.
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe ASCVD.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
COPD, Multiple MI's, Multiple CVA's. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/24 , 19 82 , to 5/30 , 19 82 , that (I) (we) lost saw the deceased alive on 5/30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
Resident | | | | 22c. DATE SIGNED
5/30/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. MacHardy MD. | | | | 22e. ADDRESS
St Agnes Hospital Balt. Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. Gar. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Avenue | | | | ADDRESS
21229 | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|------------------|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOYCE A. DE SHIELDS | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 5 9 19 82 | | | | 2b. HOUR
8:05 P M | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 31 57 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
24 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
5 9 19 82 | | 2d. HOUR
P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
wooded area - Seminole Ave. & Kevin Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1656 Abbottson St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. DeShields | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Thomas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
William DeShields 2117 E. Chase St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
9630 IMMEDIATE CAUSE (a) <u>Strangulation</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 5-9- 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject was strangled. | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
wooded area | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Seminole Ave. & Balto. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED
5-10-82 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Co. MD | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H, Inc. | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<i>Thomas J. ...</i> | |

MAY 14 1982

100-100000



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

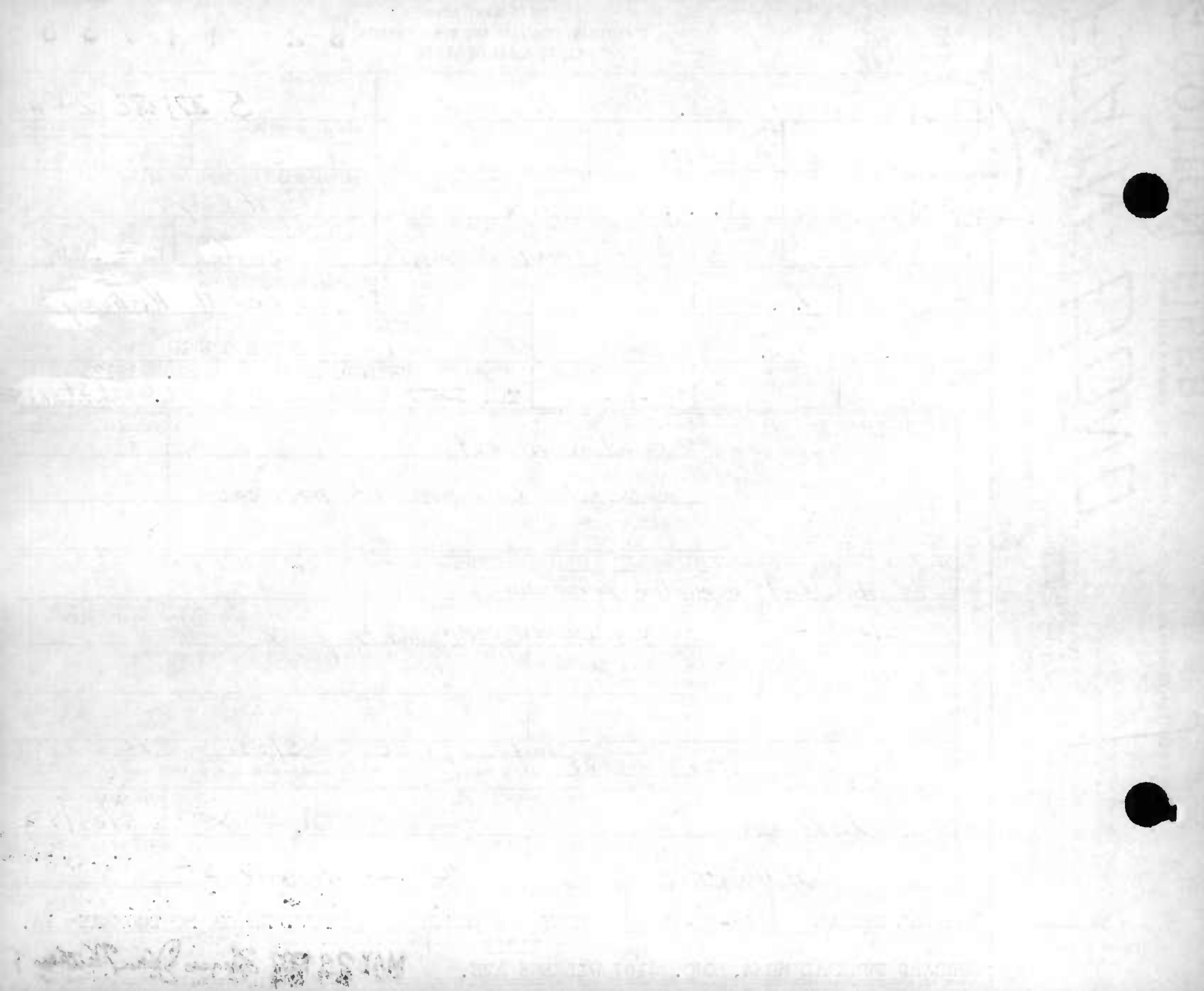
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised of it.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 1 9 6 6 | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MARY MIDDLE A. LAST DIAMOND | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 27 82 | | | | 2b. HOUR
230 AM | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 31 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
So. Balt General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY
NAVY YARD | | | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
ARNOLD | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1182 BUNKER AVENUE, 21012 | | | |
| 14. FATHER'S NAME
FIRST JOHN MIDDLE Q. LAST ADAMS | | | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE LAST UNKNOWN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
185-09-7654 | | 17. INFORMANT PHILADELPHIA PA. 19125
THE BURNS FUNERAL HOME 1425 E. COLUMBIA AVE | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest.</u>
1579
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>metastatic carcinoma of pancreas</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>bilateral aspiration pneumonia</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
5/20/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
acute abdomen, emphysema of subdiaphragm | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10/82</u> to <u>5/22/82</u> , that (I) (we) last saw the deceased alive on <u>5/22/82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>M. Meyer</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/21/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S.H. Meyer | | | | 22e. ADDRESS
3001 S. Hanover St | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
REMOVAL/BURIAL | | 23b. DATE
06-01-82 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY SEPULCHER | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PHILADELPHIA MONTGOMERY PA. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAY 28 1982 <u>Phoness Jean R. H...</u> | | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 6 7 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST
Tobias W. Diamond, Jr. | | | | MONTH DAY YEAR HOUR
5-8-82 M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| male | | W | | MONTH DAY YEAR
8-19-28 | | 53 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| PENNSYLVANIA | | U.S.A. | | | | BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTO. | | CHURCH HOSPITAL | | CHAFFEUR | | TRUCKING | |
| 13a. STATE | | | | 13b. COUNTY | | | |
| MD. | | | | BALTO. | | | |
| 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| BALTO. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tobias W. Diamond, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Stover | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | |
| YES | | | | W.W. II | | 197-20-2165 Mrs. Dorothy E. Nuth - 538 N. Luzerne Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
4100
DUE TO, OR AS A CONSEQUENCE OF:
(b) From Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF:
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 18a. DATE OF OPERATION | | 18b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 18c. AUTOPSY? | | 18d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1976 to 5-8-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | 22b. SIGNATURE
DEGREE
Thomas W. Nuth, MD | | 22c. DATE SIGNED
5-10-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| T. W. NUTH | | 479 S. Charles St | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| CREMATION | | 5-11-82 | | GREENMOUNT CREMATORY | | BALTO. MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Dorothy E. Nuth - 2334 Jefferson St | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | MAY 10 1982 | | Thomas W. Nuth | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

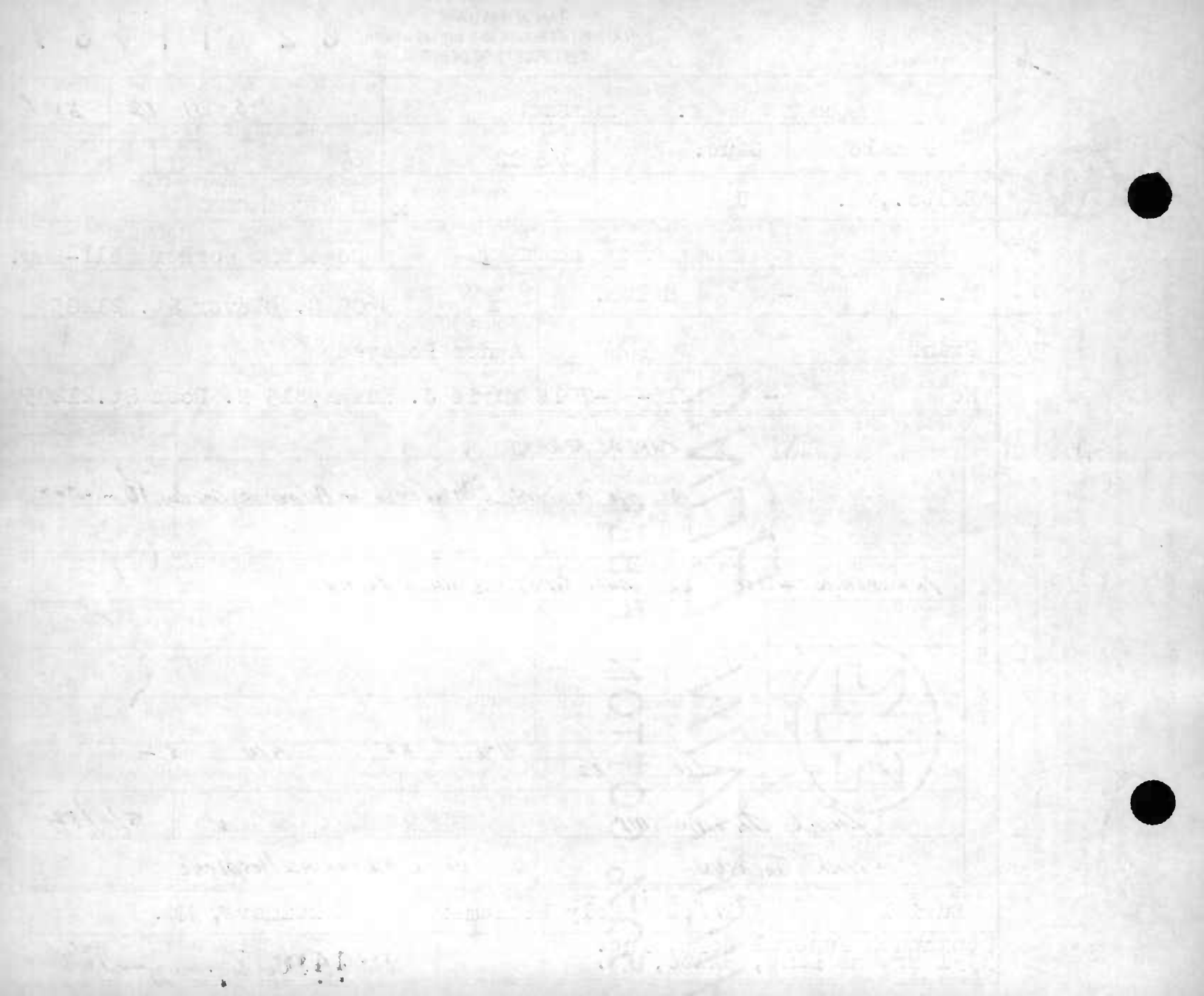
| | | | | | | | | |
|--|------------------------------|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| RUSSELL | | | DIEHL | | | 5-7-82 9:30 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| Male | White | 1-28-24 | 58 YRS. | | | 4 MONTHS | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| VA. | USA | | BALTIMORE MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | Seton Hill MANOR | | unemployed | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| MD | | | --- | | | Baltimore | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13d. STREET ADDRESS | | |
| Paul R. Diehl | | | V. Virginia VanLear | | | 5207 Hampnett Avenue | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| No | | | 218-22-6993 | | | Seton Hill Nursing Home Records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
<u>4140</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic Heart Disease</u>
(c) <u></u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>PHOCO MELIA, S/P Transcatheter aortic regurgitation</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-5-81</u> , to <u>5-7-82</u> , that (I) (we) last saw the deceased (above) <u>4-26-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) saw the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | DEGREE
<u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| SUKH DEV | | | AUSLA 5400 OLD COURT RD RANDALLS TOWN MD 21133 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | | 5/11/1982 | | Lakeview Cemetery | | Sykesville Carroll Md. | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Lemmon-Mitchell-Wiedefeld | | | 10 W. Padonia Rd. 0 1082 | | | <u>[Signature]</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, except it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 6 9 | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
BARBARA C. DIERSZEN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 11 82 | | 2b. HOUR
231 PM | | | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
6/8/12 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Emp. | | | |
| 13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
609 N. Glover St. 21205 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frank Cada | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Agnes Posavad | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No - | | | | 16b. SOCIAL SECURITY NO.
218-30-7014 | | 17. INFORMANT ADDRESS
Marie J. Kuzma, 815 N. Rose St. 21205 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
<u>4100</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Possible myocardial Infarction or Pulmonary Embolus 10 minutes</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a:
<u>Pneumonia - acute and mild congestive heart failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/30</u> , 19 <u>82</u> , to <u>5/11</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Frank Jackson MD</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>5/11/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>FRANK JACKSON</u> | | | | | | 22e. ADDRESS
<u>UNION MEMORIAL Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<u>Burial</u> | | | | 23b. DATE
<u>5/15/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer</u> | | 23d. LOCATION
<u>Baltimore, Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc.</u>
<u>3331 Brehms Lane, Balto., Md.</u> | | | | | | 25a. DATE RECD. BY REGISTRAR
<u>MAY 14 1982</u> | | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

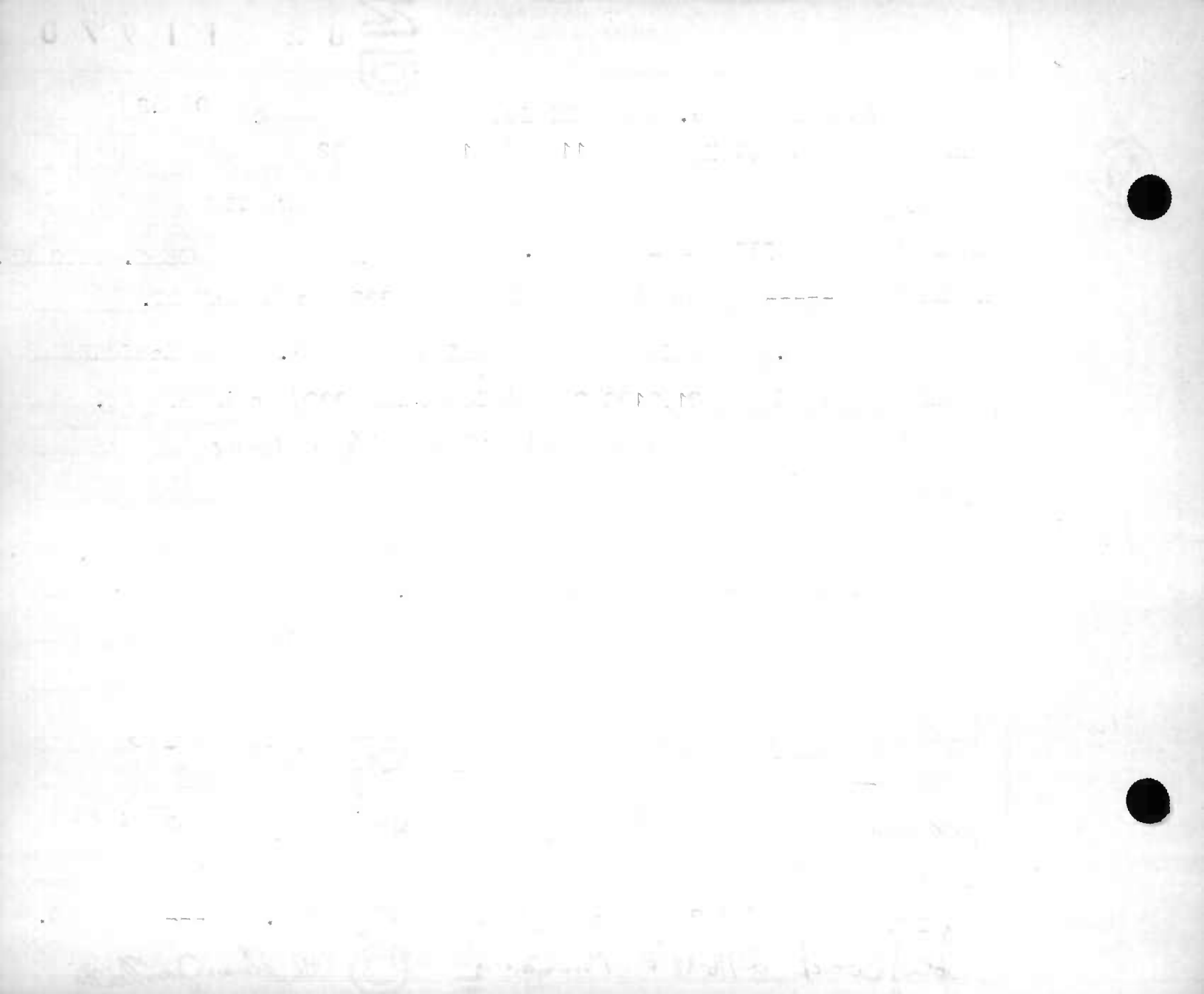
8 2 1 1 9 7 0

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDWARD S. DIMICK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05 06 82 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
11 09 1889 | 6. AGE (IN YEARS LAST BIRTHDAY)
92
YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3025 McELDERRY ST. | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. MOTOR VE | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
3025 McELDERRY ST. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD R. DIMICK | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZA A. LeFLORE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I | 17. INFORMANT
ADDRESS
MARIE MORLAN 3025 McELDERRY ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic coronary artery disease
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Cerebrovascular Insufficiency | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-6 , 19 82 , to 5-6 , 19 82 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Marion C. Kowalewski MD | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
5-6-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARION C. KOWALEWSKI MD | 22e. ADDRESS
8604 HARFORD RD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
5/8/82 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETREY | 23d. LOCATION
CITY OR TOWN
BALTO. | COUNTY
BALTO. | STATE
MD. |
| 24. FUNERAL DIRECTOR
NAME
Phy Coach | | ADDRESS
2716-18 E. Monument St. | 25a. DATE REC'D. BY REGISTRAR
MAY 7 1982 | 25b. REGISTRAR'S SIGNATURE
Marion C. Kowalewski | |

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
1 - STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 1 1 9 7 1
REG. NO. | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Agnes Ditzel | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 28 82 | | 2b. HOUR
4 12 P |
| 3. SEX
Female | 4. RACE
Caucasian White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 27 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital of Balto INC. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
clerical |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
5704 PARK Heights Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
J. Hobson Burton | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace Webster | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
UNKNOWN | | 17. INFORMANT
ADDRESS
Sandra Geffert, 4114 Font Hill Dr.
Ellicott City Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction (cardiogenic shock)
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 5/28 19 82 to 5/28 19 82 , that (I) (we) lost
saw the deceased alive on 5/28 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. Hettelman 9161 | | DEGREE | | 22c. DATE SIGNED
5/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Hettelman | | 22e. ADDRESS
Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
5/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cemetery Deal Isl., Som. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Leroy Webster | | Rt. 3, Box 354
ADDRESS
Princess Anne, Md. | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1982 | |

STINGER AND ASSOCIATES
P.O. BOX 354
JUL 3 1987
JUL 3 1987

STINGER AND ASSOCIATES

STINGER AND ASSOCIATES

STINGER AND ASSOCIATES

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JUL 3 1987

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STINGER AND ASSOCIATES

72
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8211972 | |
|--|--|------------------------------|--|--|---|--|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| Mary K. Dixon | | | | | | May 16, 1982 | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Female | | Black | | 11 27 27 | | 54 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| N.C. | | USA | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | 2117 Walbrook Avenue | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | |
| MD | | | | | Baltimore | | | | 2117 Walbrook Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| Clarence A. Wilson | | | Mabel B. Calawell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | | | 217-14-6152 Willie Mae Sawyer 806 N. Bentalou St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> | | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HASCD</u> | | | | | | | | | | 2 yrs. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>80</u> , to <u>May 16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>May 3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| <u>Benigno R. Lazaro</u> | | | <u>M.D.</u> | | | | | | 5-18-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| BENIGNO R. LAZARO | | | 59 Dundalk Ave Balt Md 21222 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | | 5/19/82 | | Arbutus Mem. Park | | Baltimore Co. MD | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | MAY 19 1982 | | <u>Kevin J. Nathan</u> | | | |

STILL 11115

NOTICE

11115

STILL 11115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a possible homicide.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 1 9 7 3 | | | |
|---|--|---|--|---|--|--|--|
| FOR
1- STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) RENA C. DIXON | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 12, 1982 | | 2b. HOUR
0330 A.M. | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 5 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. of MD HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Factory worker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
BALTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John H Thomas | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Blanche M Makiel | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
? | | 16b. SOCIAL SECURITY NO.
217 24 1104 | |
| 17. INFORMANT
ADDRESS
HOSP. CHART | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
5609
DUE TO, OR AS A CONSEQUENCE OF
(b) ADULT RESPIRATORY DISTRESS SYNDROME
DUE TO, OR AS A CONSEQUENCE OF
(c) PRESUMED SEPSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hrs
2d
<1wk | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Small bowel obstruction (RECURRENT) | | | | | | | |
| 19a. DATE OF OPERATION
5/4/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Small bowel obstruction | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 3 19 82 , to MAY 12 19 82 , that (I) (we) last saw the deceased alive on MAY 12 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Scott H. Kutzman | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SCOTT H. KUTZMAN | | 22e. ADDRESS
U. of MD HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Co. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 14 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 7 4 | |
|--|--|---|--|---|--|--|---|---|----------------------|--|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| Zola Huff Dobson | | | May 2 1982 | | | | | | 3:00A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | MONTH DAY YEAR
Feb 17 1893 | | 89 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Indiana | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 3203 Frisby St 21218 | | | | Teacher | | Balto County | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | | | ----- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3203 Frisby St 21218 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST
Alfred Amos Huff | | | FIRST MIDDLE LAST
Louisa Swank | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | | ----- | | 218-36-8588 Joseph H. Dobson 202 Headington Ct 21093 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
<u>4140</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ARTRIO-SCLECTIC HEART DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>7PS</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>2 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 19 61</u> to <u>5-3-82</u> , that (I) (we) last saw the deceased alive on <u>4-19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Francis T. Daly</u> | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5-3-82</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| Dr. Francis T. Daly | | | 4300 N. Charles St | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| Burial | | | 5-6-82 | | Oak Hill Cemetery | | Plymouth Indiana | | | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home 6500 York Rd 21212 | | | | | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAY 7 1982 <u>Charles J. Nathan</u> | | | | | |



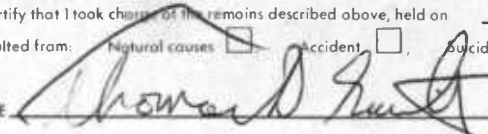

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph G. Doboy | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
5 27 1982 | | | 2b. HOUR
5:06 P M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
70-17-1915 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
66 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
5 27 1982 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Radiologist | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical |
| 13a. STATE
N.J. | | | 13b. COUNTY
Ocean | | 13c. CITY OR TOWN
Toms River | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jesse G. Doboy | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Brown | | | 16. SOCIAL SECURITY NO.
201-01-6108 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | | 17. INFORMANT
ADDRESS
Winifred H. Doboy Toms River, N.J. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Stab wound of chest</u>
9660
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR MIN MONTH DAY YEAR
4:52 M. 5 27 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)
Subject stabbed | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
house | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
607 Goucher Blvd. Towson Balto. Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | DATE SIGNED
5/28/82 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | ADDRESS
111 Penn ST. Balto., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
6-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Ocean Co. Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Toms River Ocean N.J. | |
| 24. FUNERAL DIRECTOR
NAME
Paul R. Crouch | | | ADDRESS
North East, Md. | | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

631156



WILLIAM
F. BROWN
100 WALL STREET
NEW YORK, N.Y. 10038

[Handwritten signature]

[Handwritten signature]

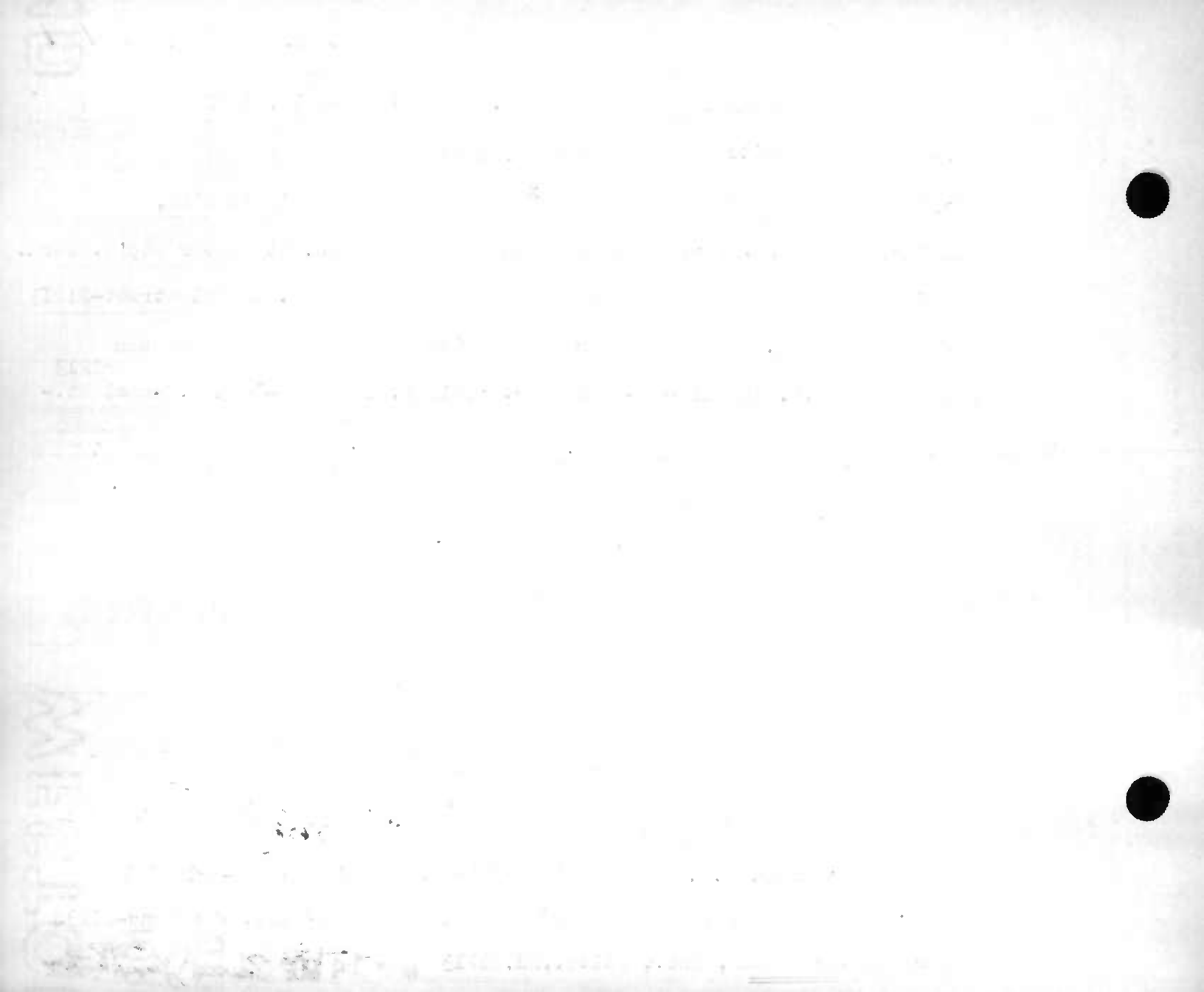
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| FOR Item 13b cn | | | | | STATE OF MARYLAND | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1- STATE REGISTRAR | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | |
| | | | | | CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | |
| (TYPE OR PRINT) <u>McDania D. Nowlin Dockery</u> | | | | | MONTH DAY YEAR | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| <u>Female</u> | | | | | <u>black</u> | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR | | | | | MONTHS DAYS HOURS MIN. | | | | |
| <u>2/09/13</u> | | | | | <u>69</u> YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| <u>VA.</u> | | | | | <u>U.S.A</u> | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| | | | | | <u>Baltimore City</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | |
| <u>Baltimore</u> | | | | | <u>South Baltimore General</u> | | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE | | | | | 13b. INSIDE CITY LIMITS? | | | | |
| <u>MD</u> | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| <u>Charles Nowlin</u> | | | | | <u>Lorena Nowlin</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| <u>unknown</u> | | | | | <u>231-12-5472</u> | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| <u>Joan Adams</u> | | | | | <u>229 Bishop Ave.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>cardiac arrest</u> | | | | | | | | | |
| 1890 | | | | | | | | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Abdominal carcinoma;</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal cell carcinoma, right Kidney</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| <u>Acute abdomen</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| | | | | | | | | | |
| 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY | | | | |
| | | | | | HOUR A.M. MONTH DAY YEAR | | | | |
| | | | | | P.M. 19 | | | | |
| 21c. INJURY OCCURRED | | | | | 21d. PLACE OF INJURY | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| | | | | | 21f. LOCATION | | | | |
| | | | | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> 19 <u>82</u> , to <u>4-27</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4-27-82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | |
| <u>B. Winston</u> | | | | | <u>5/23/82</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| <u>B. Winston</u> | | | | | <u>South Baltimore General Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | |
| <u>Burial</u> | | | | | <u>6/2/82</u> | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION | | | | |
| <u>Cedar Hill</u> | | | | | CITY OR TOWN COUNTY STATE | | | | |
| | | | | | <u>Brooklyn AA Co. Md.</u> | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D BY REGISTRAR | | | | |
| NAME ADDRESS | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| <u>Chas A. Rice FSPA 1300 Eutaw Pl.</u> | | | | | <u>JUN 3 1982</u> | | | | |

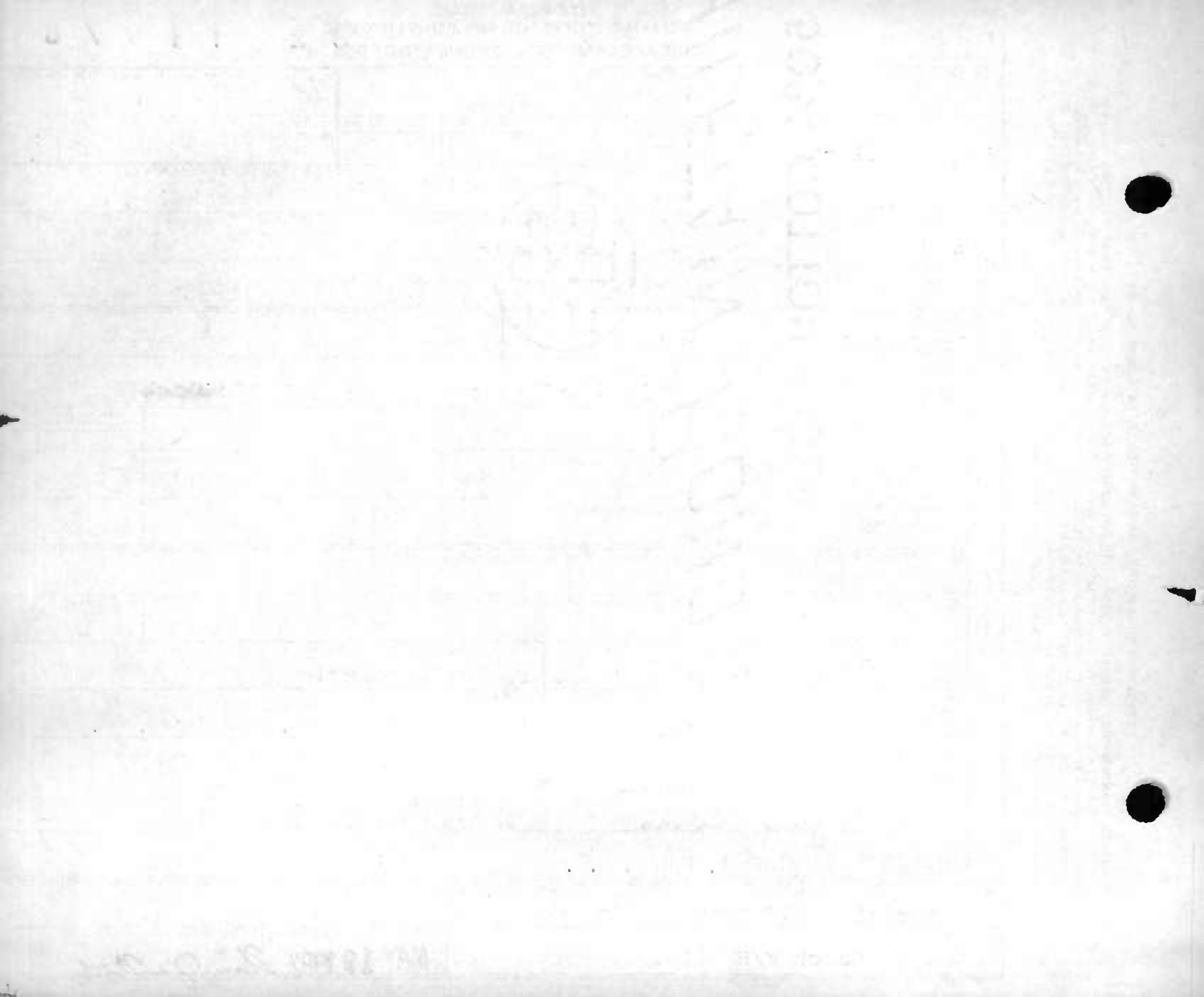
2/20/2



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 11978 | |
|--|-------------------------|---|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Jerome E. Dotson | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5 18 1982 | | 2b. HOUR 5:15 a.m. | | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR 4 30 47 | 6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 5 18 1982 | 7d. HOUR 5:15 a.m. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4147 Park Heights Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3212 Walbrook Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vanderbilt Dotson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Watson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-44-3729 | | 17. INFORMANT ADDRESS
Mary Watson 5433 Whitlock Road | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke Inhalation
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
4:15 PM 5 18 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject in housefire | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
House | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
4147 Park Heights Ave., Baltimore, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED
5-18-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1982 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|-------|--|-------|--|----------|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 1 9 7 9 | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| PRENTIS (PRENTISS) T. DOUGHTY | | | | | | | | 5 | | 22 | | 82 | | 12:45 | | am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| Male | | Black | | 6 26 DAY 10 YEAR | | 71 | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| VA | | USA | | | | BALTIMORE CITY, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| BALTIMORE | | VAMC BALTIMORE, MARYLAND 21218 | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | |
| MD | | Pasadena | | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 137 Shell Cove Court | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | | | | |
| Douglass | | Doughty | | | | Laura | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Yes | | 215-12-0949 | | Prentis L. Doughty | | 137 Shell Cove Ct | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Globostrong Multiforme</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 4</u> , 19 <u>82</u> , to <u>MAY 22</u> , 19 <u>82</u> , that (X) (we) last saw the deceased alive on <u>MAY 22</u> , 19 <u>82</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| <u>A. B. Bach MD</u> | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| A. B. Bach MD | | 3900 LOCH RAVEN BLVD 21218 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Burial | | 5/27/82 | | King Mem. Pk. | | Baltimore | | Co. | | MD | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| NAME | | ADDRESS | | | | | | | | | | | | | | | |
| Wm. C. March F/H | | 1101 E. North Ave. | | | | <u>Francis J. Harkins</u> | | | | | | | | | | | |
| MAY 24 1982 | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 1 9 8 0 | | | | | |
|--|--|---|--|--|--|--|--|---|--|--|----------|---|---------------------|---|--|
| FOR
1- STATE
REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
BERTHA | | MIDDLE | | LAST
DOUGLAS | | 2a. DATE OF DEATH | | MONTH
5 | DAY
4 | YEAR
82 | 2b. HOUR
3 P. M. | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH | | MONTH
3 | | DAY
30 | | YEAR
03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN HOSP. BALTO MD. | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS
1150 LONGWOOD ST | | 13c. CITY OR TOWN
BALTO. | | 13d. STREET ADDRESS
1150 LONGWOOD ST | | | |
| 14. FATHER'S NAME
FIRST
James | | MIDDLE
Richmond | | LAST
MARY | | 15. MOTHER'S MAIDEN NAME
FIRST
MARY | | MIDDLE
DRAULS | | LAST
DRAULS | | 16. SOCIAL SECURITY NO.
577-32-1028 | | | |
| 17. INFORMANT
Elizabeth Douglas | | ADDRESS
S/A | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>
4360
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Diabetes mellitus</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>5/3/82</u> to <u>5/4/82</u> , that (I) (we) last saw the deceased alive on <u>5/4/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Kyant | | DEGREE | | 22c. DATE SIGNED
5/4/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K YAW NYUNT | | 22e. ADDRESS
LUTHERAN HOSPITAL | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-9-82 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Sweet Protestant | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
S.C. | | 24. FUNERAL DIRECTOR
NAME
Bedwin-Thompson F.H. | | ADDRESS
1913 W. BALBO ST. | | 25a. DATE REC'D. BY REGISTRAR
MAY 5 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jean Nathan | | 25c. DATE REC'D. BY REGISTRAR
MAY 5 1982 | | | |

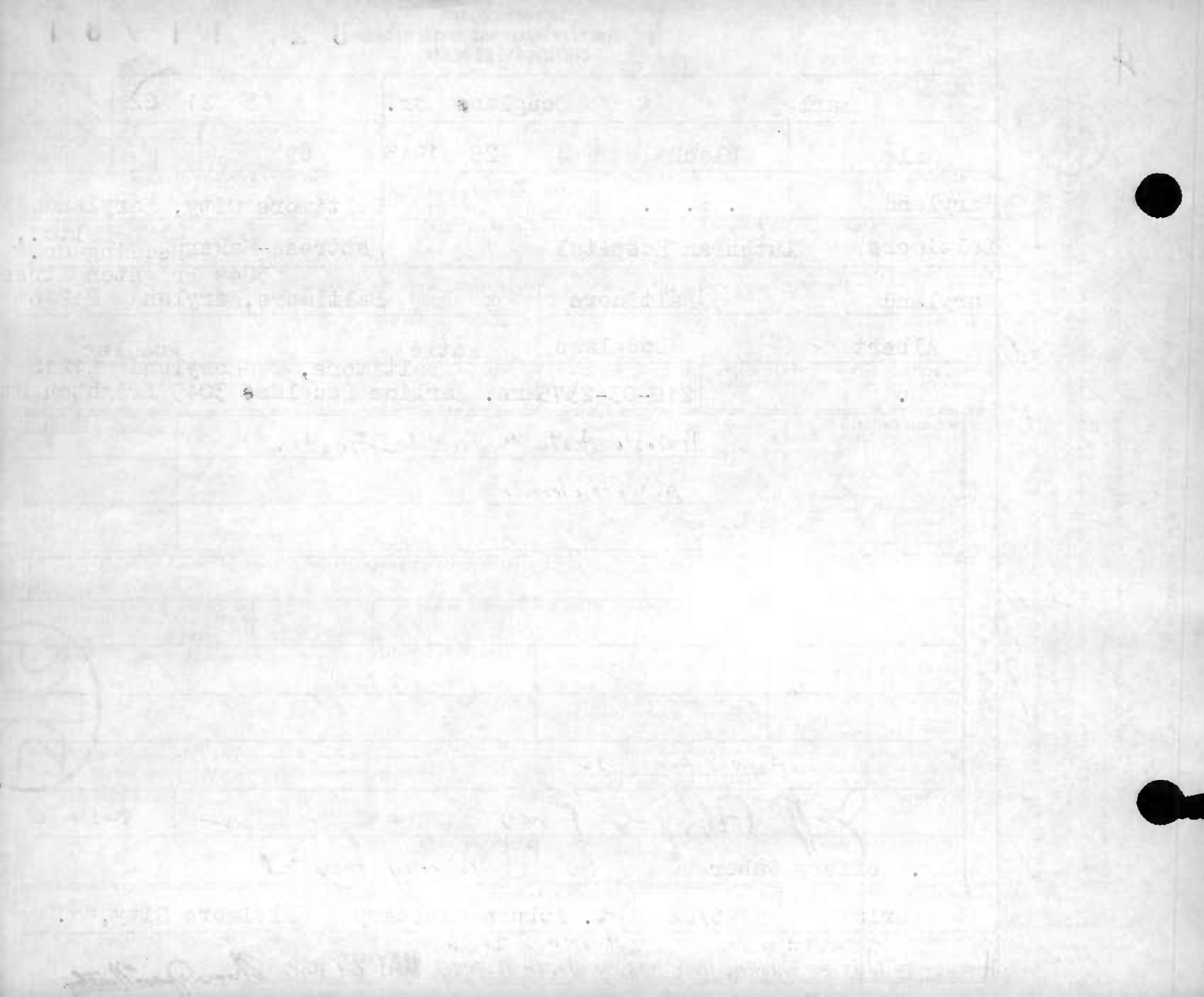
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | | | |
|---|--|--|---|--|--|--------------------------------------|--|---|---|--|--|---------------------------------------|--|
| 8 2 1 1 9 8 1 | | | | | | | | | | | | | |
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 20. DATE OF DEATH | | MONTH | | DAY | YEAR | 2b. HOUR | | |
| Earl Douglas Sr. | | | | | 5 | | 21 | | 82 | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | Black | | 4 28 1913 | | 69 | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U. S. A. | | | | Baltimore City, Maryland MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Lutheran Hospital | | | | | | Mattress-Maker | | Bedding Co. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3049 Brighton Street Baltimore, Maryland 21216 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Albert Douglass | | | | | Katie Fuddler | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | ADDRESS | |
| No | | | | | 218-03-2375 | | Baltimore, Maryland 21216 | | | | | Mrs. Earline Douglas 3049 Brighton St | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) Probable Acute Myocardial Infarction | | | | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK | | | | | STREET | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>Approx. April 19, 72</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | | | |
| <u>Jeff Gaber, MD</u> | | | MD | | | | | 5-24-82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | | | |
| Dr. Jeffery Gaber MD | | | | | Mercy Hospital | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | |
| Burial | | | 5/26/82 | | Mt. Auburn Cemetery | | | CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | Baltimore City, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| NAME ADDRESS | | | | | | | | | | | | | |
| HERBERT E. NUTTER Funeral Home 3035 W. NORTH AVENUE | | | | | MAY 27 1982 | | <u>James J. Nutter</u> | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 8 2

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John Edward Douglas | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 30, 1982 | | | 2b. HOUR pm
1:30 M | | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
10 10 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 72 HRS. HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
524 N. Charles Apt. 1312 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lab. Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY
Industrial | | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
524 N. Charles Apt. 1312 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Douglas | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rose G. Sullivan | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | |
| 16b. SOCIAL SECURITY NO.
218-03-7205 | | | 17. INFORMANT
Joseph Douglas | | | ADDRESS
300 Southerly Drive | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4100
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Adenocarcinoma of colon. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27 , 19 80 , to 3/15 , 19 82 , that (I) (we) last saw the deceased alive on 3/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
S. Munda | | | DEGREE | | | 22c. DATE SIGNED
6/1/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SURYA P. MUNDRA | | |
| 22e. ADDRESS
203 E PATAPSCO Ave Balt MD 21225 | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
6/3/82 | | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore A.A. Md. | | | 24. FUNERAL DIRECTOR
Gonce Funeral Home | | | ADDRESS
4001 Ritchie Hwy Balto, Md. 21225 | | | DATE REC'D. BY REGISTRAR
JUN 2 1982 | |

5. STATE OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 8 3

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ANNIE E. DWELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05-16-82 | | 2b. HOUR
1:42 AM | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 26 92 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89
YRS MONTHS DAYS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MO | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest Scott | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Hall | | 13e. STREET ADDRESS
5307 Fern Park Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
ADDRESS
Jean E. Little 5307 Fern Park Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
4278
DUE TO, OR AS A CONSEQUENCE OF
(b) HEART BLOCK
DUE TO, OR AS A CONSEQUENCE OF
(c) SICK SINUS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 12th 19 82 to MAY 16th 19 82 that (I) (we) last saw the deceased alive on MAY 16th 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
BEN MAGNUS-LAWSON MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-16-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OF PRINT)
BEN MAGNUS-LAWSON MD | | 22e. ADDRESS
PROVIDENT HOSPITAL BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Bursal | | 23b. DATE
5/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat'l | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles Van Nuthan | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 1 9 8 4
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|---|--|--------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JOHN J. (F.) DRESSEL | | | | May 7, 1982 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | White | Nov. 17, 1918 | | 63 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | | | Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | 2762 Pelham Ave. | | | Machinist | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | | | | | Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| George Dressel | | | | Marie Trentler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| Yes | | WW II | | Mr James W Dressel | | 1502 Marie Ct Finksburg, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma lungs</i>
1629
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Arteriosclerotic Cardiovascular disease</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE <i>Grato V. Patricio, M.D.</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>5/10/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Grato V. Patricio, M.D. | | | | 2926 E. Coldspring Lane | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | May 11, 1982 | | Gardens of Faith | | Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR | |
| Leonard J. Ruck, Inc. ADDRESS Baltimore, Md. | | | | MAY 10 1982 | | <i>Charles J. ...</i> | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 8 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--------------------|---|-------------------|---|-------------------|---|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
<u>Lester</u> | MIDDLE
<u>T</u> | LAST
<u>Drew</u> | 2a. DATE OF DEATH | | MONTH
<u>5</u> | DAY
<u>16</u> | YEAR
<u>82</u> | 2b. HOUR
<u>12¹⁰ P.M.</u> |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>USA</u> | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS
<u>YRS.</u> | | IF UNDER 24 HRS.
HOURS
<u>MIN.</u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>VA</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Baltimore City Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<u>MD</u> | | 13b. COUNTY | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<u>3600 Reisterstown Rd.</u> | | |
| 14. FATHER'S NAME
FIRST
<u>Richard</u> MIDDLE
<u>Bowden</u> LAST
<u>Bowden</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST
<u>Mary</u> MIDDLE
<u>Frazier</u> LAST
<u>Frazier</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO.
<u>216-05-9528</u> | | 17. INFORMANT
<u>Hilda Brown</u> ADDRESS
<u>3600 Reisterstown Road</u> | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopalm arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>4275</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>arrest</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-20</u> 19 <u>81</u> , to <u>5-16</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5-16</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Amy R. Heil</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>5-16-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Amy R. Heil</u> | | 22e. ADDRESS
<u>Baltimore City Hospital</u> | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>5/22/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>King Memorial Pk.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore Co. MD</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>Wm. C. March F/H</u> ADDRESS
<u>1101 E. North Ave.</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>MAY 19 1982</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 8 6

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELNORA DUBOIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 22, 1982 | | 2b. HOUR
10:30 PM | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 19, 1946 | | 6. AGE (IN YEARS LAST BIRTHDAY)
35 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tip Top Motor Court | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Elkridge | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
6251 Washington Blvd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Deitz | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leora Bell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-46-8094 | | 17. INFORMANT
Mr. Robert Dubois Elkridge, Md. 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
4151
DUE TO, OR AS A CONSEQUENCE OF
(b) PROBABLE PULMONARY EMBOLISM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/6/82 , 19 82 , to 5/22 , 19 82 , that (I) (we) last saw the deceased alive on 5/22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Mary Hotchkiss MD | | | | DEGREE
MD | | | 22c. DATE SIGNED
5-22-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARY HOTCHKISS | | | | 22e. ADDRESS
601 N. BROADWAY BALTO MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Old Salem Luth. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Loring Byers Funeral Directors
ADDRESS
8728 Liberty Rd. Randallstown, Md. 21133 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The attesting physician's signature and seal must be retained by the hospital or attending physician. The death certificate is to be returned to the State Department of Health and Mental Hygiene after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the State Department of Health and Mental Hygiene. Page 4 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it is to be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8 2 1 1 9 8 7 | |
|--|---|--|--|--|---|---|
| FOR
1. STATE
REGISTRAR | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
SHERMAN A. Duckett | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 2 '82 | | 2b. HOUR
6:50 PM | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
7 3 35 | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 8. BIRTHPLACE
(COUNTRY)
China | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen. | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 17. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS
3422 Childs Ct. | |
| 19. FATHER'S NAME
FIRST MIDDLE LAST
James Duckett | | | 20. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Duckett | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 22. SOCIAL SECURITY NO.
579-50-1027 | | 23. INFORMANT
Mary Braxton 3422 Childs Ct. | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPOXEMIA
4940 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which } (b) BRONCHIECTASIS
gave rise to immediate }
cause (a), stating the } DUE TO, OR AS A CONSEQUENCE OF
underlying cause lost. } (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Left UPPER LOBE LUNG MASS / Pulmonary Tuberculosis history | | | | | | |
| 25a. DATE OF OPERATION | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 26a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 26b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 27b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 28a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 28b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 28c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 29. I certify that (I) (this hospital) attended the deceased from May 2, 19 82, to MAY 2, 19 82, that (I) (we) lost
saw the deceased alive on May 2, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 29a. SIGNATURE
Barbara Fretwell MD | | DEGREE | | 29b. DATE SIGNED
May 2 '82 | | 29c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 30a. PHYSICIAN'S NAME (TYPE OR PRINT)
Barbara Fretwell | | 30b. ADDRESS
S. Baltimore General Hospital | | | | |
| 31a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 31b. DATE
5/6/82 | 31c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. Cem. | | 31d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville, Md. | | |
| 32. FUNERAL DIRECTOR
NAME
Leroy O. Ayott 4600 Liberty St. | | 32a. DATE REC'D. BY REGISTRAR
MAY 7 1982 | | 32b. REGISTRAR'S SIGNATURE
Charles Jean Nantke | | |

A4 22 2 1

1. 100

343

1000

10/10/10

507

John Doe

1902 Club G.

about

219 20 1st May 1978

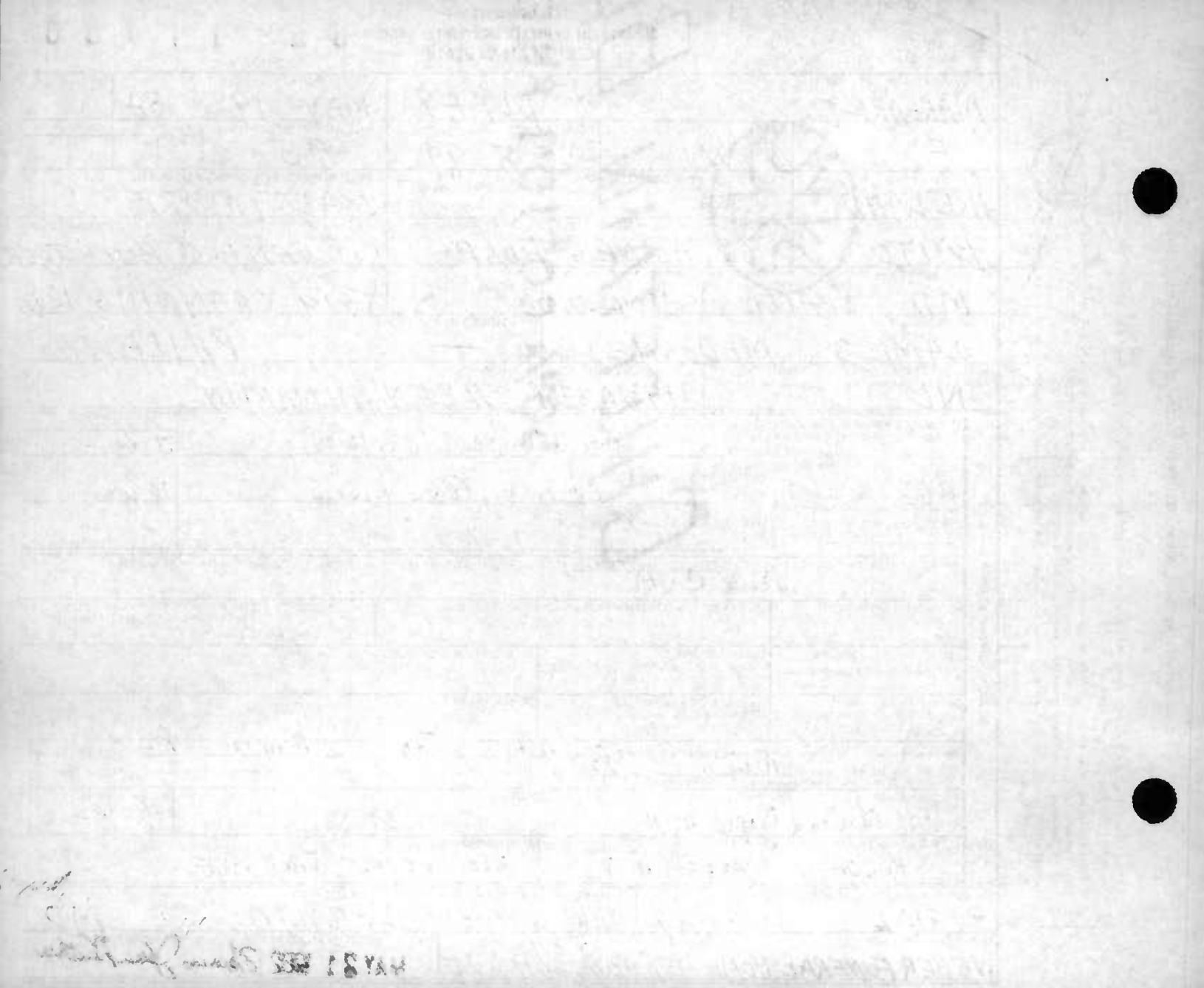
Kumpu 2/10/22
 Kumpu 2/10/22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified by the funeral director.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|-------------------|--|--|--|--|
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | |
| MARGARET DUFFY | | | | | MAY 19 '82 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7b. HOUR | |
| F | | W | | 5 8 99 | | 83 | | M | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| IRELAND | | USA | | NEVER MARRIED | | BALTIMORE CITY | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTO | | ST. AGNES HOSP | | KITCHEN ASST | | BOY SEEDOR | | | |
| 13a. USUAL RESIDENCE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | 13d. INSIDE CITY LIMITS? | | | |
| MD BALTO | | CATHOLIC | | 5319 CHANNING RD | | YES | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| JAMES McDONNELL | | PHILBRY | | NO | | 21926330 | | EILEEN KILMARTIN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | 3 hours | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) | | | | | | | | 10 years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Acute CVA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES | | YES | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. LOCATION | | | |
| OR CONTRIBUTING CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | CITY OR TOWN | | COUNTY STATE | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | | | BALTO | | MD | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. DATE SIGNED | | | |
| WHILE AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | 5/19/82 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME | | | |
| May 4, 1982 | | Kennard Yaffe M.D. | | 5/19/82 | | KENNARD YAFFE M.D. | | | |
| 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | | 22h. REGISTRAR'S NAME | | | |
| 5501 FOREST PARK AVE | | MAY 21 1982 | | Charles J. [Signature] | | JMD | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | 5/22/82 | | NEW CATHEDRAL | | BALTO | | | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | | |
| WEBER FUNERAL HOME | | EDMONDSON AVE | | 5311 | | MAY 21 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 8 9

REG. NO.

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Paul REVERE Dugan | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 1 82 | | 2b. HOUR
1:40 PM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
5 - 16 - 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BALTIMORE CITY HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | 12b. KIND OF BUSINESS OR INDUSTRY
OF EDUCATION |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
DUNDALK | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEROY GEORGE DUGAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALICE MARGARET MINTER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
W.W. 2 181.03.9769 | 17. INFORMANT
RUTH E. DUGAN | |
| | | ADDRESS
SAME AS 13c | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>respiratory collapse</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>lung cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>82</u> , to <u>5/1</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/1</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death. | | | | |
| 22b. SIGNATURE
<u>Lloyd Stall</u> | | DEGREE | | 22c. DATE SIGNED
<u>5/1/82</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Lloyd Stall</u> | | 22e. ADDRESS
<u>Baltimore City Hospital</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5/4/1982 | 23c. NAME OF CEMETERY OR CREMATORY
CENTRAL VIEW CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BIGLERSVILLE PA. | | 24. FUNERAL DIRECTOR
NAME
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | |
| 25a. DATE REC'D. BY REGISTRAR
MAY 4 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>Frances Jean Nathan</u> | | |



NOTICE

WIND

WIND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 1 9 9 0 | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|--|--|
| FOR
1- STATE
REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Ernest Melvin Duppins | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-18/82 | | | | 2b. HOUR
4:28 P M | | | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 10 35 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
farm | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
New Windsor | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Old Springdale Rd | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Robert Duppins | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Henretta ? | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no n/a | | | | 16b. SOCIAL SECURITY NO.
218-30-9205 | | 17. INFORMANT
ADDRESS
Anna Simms Old Springdale Rd | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE
0384
DUE TO, OR AS A CONSEQUENCE OF
(b) GRAM NEGATIVE SEPSIS.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min.
2 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
HEPATIC FAILURE SECONDARY TO ALCOHOLISM. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from MAY 6 , 19 82 , to MAY 13 , 19 82 , that (I) have lost
saw the deceased alive on MAY 13 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated
above, (I) do (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
W. Givins McKenna | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
MAY 13 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
McKENNA | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Strawbridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
New Windsor Carroll MD | | | | | | | |
| 24. FUNERAL DIRECTOR
PRITTS FUNERAL HOME | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

MEDICAL CERTIFICATION

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Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 9 1 | |
|---|--|---|---|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Hester F. Dupree | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 13, 1982 | | | 2b. HOUR
M | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
12 12 97 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
84 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5703 Winner Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
MD | | 13b. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5703 Winner Avenue | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Dozer Flynn | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth Williamson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Maurice H. Dupree 5703 Winner Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
1809
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA OF THE CERVIX - WIDESPREAD
DUE TO, OR AS A CONSEQUENCE OF
(c) 2 YEARS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 10, 1980 to MAY 9, 1982 , that (I) (we) lost saw the deceased alive on JAN 12, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCUS TEPPE MD | | | | 22e. ADDRESS
SINAI HOSPITAL OF BALTIMORE INC. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
5/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H | | | | | | 25a. DATE REC'D BY REGISTRAR
MAY 17 1982 | | | | | |
| ADDRESS
1101 E. North Ave. | | | | | | SIGNATURE
[Signature] | | | | | |

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|---|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 1 9 9 2 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR HOUR | | | | |
| Mary Wise Duty | | | | | 5 23 82 9:00P _M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | White | | 8 MONTH DAY YEAR
8 11 1900 | | 81 YRS. | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Va. | | U.S.A. | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 100 West Jeffrey Street | | | | Machinist | | Beth. Steel | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | |
| Md --- | | | | | Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| Sillas B. Jacobs | | | | | Virginia J. Edwards | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 216-20-9901 | | Burl L. Bledsoe 3813 St. Victor St. Balto, Md 21225 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Ami. M I - Info</i> | | | | | | | | | |
| 4.00 DUE TO, OR AS A CONSEQUENCE OF <i>Aslvb - Atial Dis - P.V.C.</i> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 22 - 79</i> to <i>May - 23 82</i> , that (I) (we) lost saw the deceased alive on <i>January 82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| <i>X [Signature]</i> | | | | | | | | 5-24-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| GEORGE HAYDOCK | | | | | 3350 Wilman Dr - Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 5/26/82 | | Warrenton Cem. | | Warrenton Fauquier Va. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25. DATE REC'D. BY REGISTRAR | | | | |
| George J. Gonce 4001 Ritchie Hgwy | | | | | MAY 27 1982 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| | | | | | <i>[Signature]</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called to one.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 9 3 | | | |
|---|--|--|--|--|--|--|--|---|--|--|-----|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| ALBERT VINCENT DWYER | | | | | | | | 5-13-82 | | | | | 6:00A |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| MALE | | WHITE | | 5 05 23 | | 59 YRS. | | MONTHS | | DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | USA | | | | Baltimore, City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| BALTIMORE | | GOOD SAMARITAN | | | | Maintenance Supervisor | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1319 Walker Ave. | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| Albert Vincent Dwyer, Sr. | | | | Catherine O'Connor | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | | | 220-14-4943 | | Mrs. Rose G. Redmond | | Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1: DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u> | | | | | | | | | | | | | |
| 1539 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) <u>METASTATIC CARCINOMA</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) <u>OF COLON.</u> | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-30-82</u> to <u>5-13-82</u> , that (I) (we) lost | | | | | | | | | | | | | |
| saw the deceased alive on <u>5-12-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Sawthier</u> | | | | | | | | | | | | | |
| DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 22c. DATE SIGNED <u>5-13-82</u> | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | |
| <u>ZAW MIN</u> | | | | | | <u>5601 LOCH RAVEN BLVD. BALTO.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Cremation | | | | May 14, 1982 | | Greenmount | | CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | Baltimore City, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE RECD. BY REGISTRATION REGISTRAR | | | | | | | |
| NAME | | | | | | ADDRESS | | | | | | | |
| <u>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</u> | | | | | | <u>6500 York Rd.</u> | | <u>MAY 17 1982</u> | | | | | |

1971, 1972, 1973

70000' 5019850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

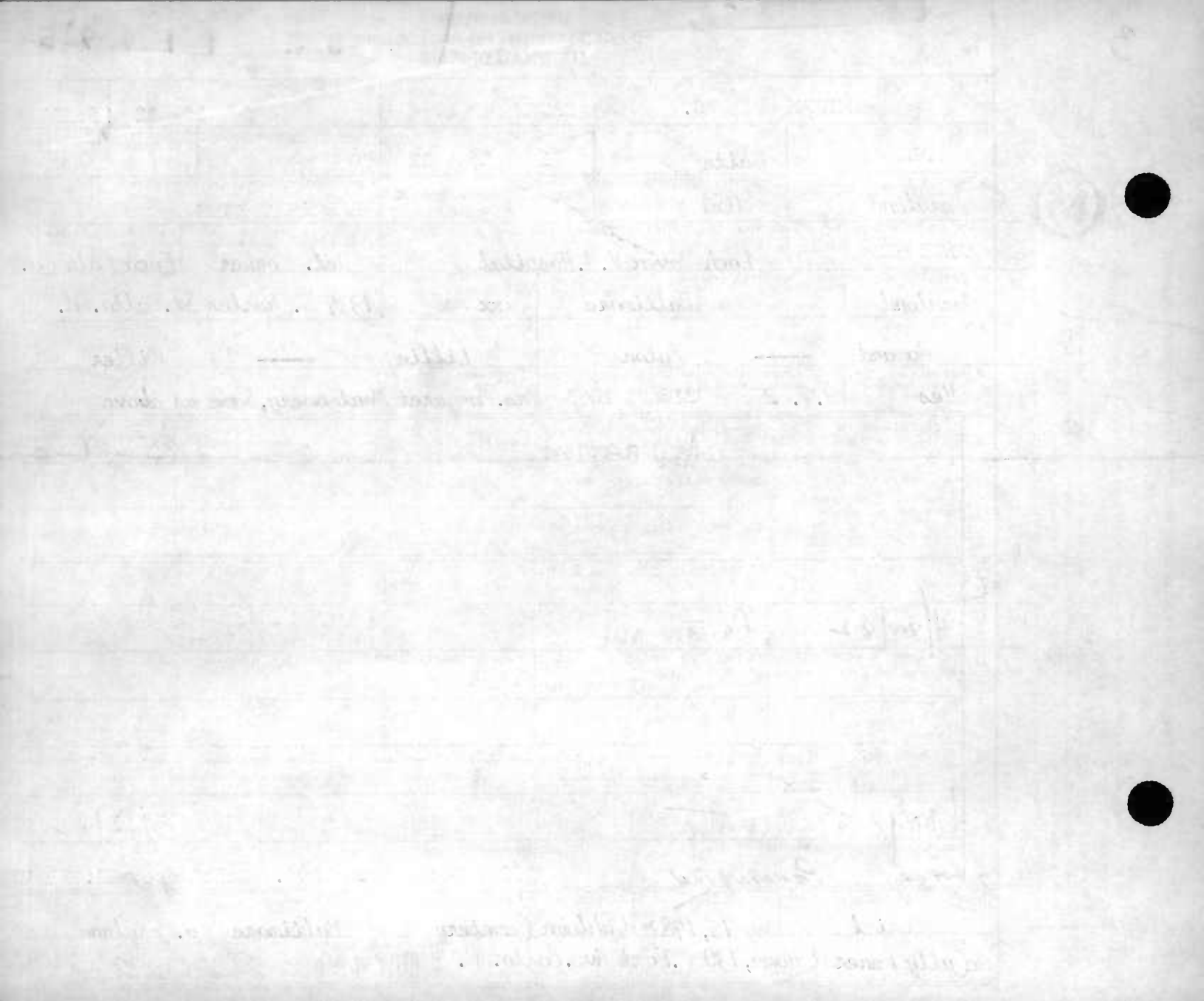
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 2 1 1 9 9 4 | | | | |
|---|--|--|---|---|---|---|--|---|---|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Nathaniel Eaton</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>5 5 82</i> | | | | 2b. HOUR
<i>8:15 PM</i> |
| 3. SEX
<i>male</i> | | 4. RACE
<i>Col</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>10 -13- 1906</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>75</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>N. C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Provident Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Barber</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Barber Shop</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>BALTO.</i> | | 13c. CITY OR TOWN
<i>BALTO.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Solomon Eaton</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Nancy Hawkins</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>213-14-0625A</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Georgia Eaton 1711 N. Fulton Ave.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Septic shock</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Septicemia & Pneumonia</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
<input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from <i>9/1/82</i> , 19 <i>82</i> , to <i>5/5</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>5/5/82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Juan C. Ruffier</i> | | | | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<i>5/5/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>JUAN C. RUFFIER</i> | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | | 23b. DATE
<i>5-11-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arbutus Mem. Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>BALTO. Co. Md.</i> | | |
| 24. FUNERAL DIRECTOR NAME
<i>Joseph L. Russ</i> | | | | | ADDRESS
<i>2222 W. North Ave.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 12 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 1 9 9 5 | | | |
|---|--|--|--|---|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NORMAN G. EATON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 12 82 | | | | | 2b. HOUR
5:55A M | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 26 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS | | 8. IF UNDER 24 HRS
HOURS MIN.
MD. | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven V.A. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Worker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Coca Cola Co. | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7339 S. Charles St. Balto. Md. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard ----- Eaton | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie ----- Miller | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE YEAR OR DATES)
Yes W.W. 2 | | | | | 16b. SOCIAL SECURITY NO.
216 03 1035 | | 17. INFORMANT
ADDRESS
Mrs. Margaret Montgomery, Same as above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration
1419
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
4/29/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ca Tongue | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 13, 1982 , to MAY 12, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 12, 1982 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <input checked="" type="checkbox"/> view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Larry Pennington | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5/12/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Larry Pennington | | | | | 22e. ADDRESS
3900 Loch Raven Blvd. Baltimore, Md. 21218 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 13 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. Hester | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 1 | 9 | 9 | 6 | | | | |
|---|--|--|---|--|---|---|---|--|--|---|---|---|--|---|---|--|--|--|---------------------|--|
| FOR
1. STATE
REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR | | | | | | | | | | |
| PAUL EATON | | | | | | | | | | 05/01/82 | | | | | | | | | | |
| 3. SEX
Male | | | | | | | | | | 4. RACE
White | | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 18, 1946 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
35 YRS. | | | 7b. HOUR
2:25M P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | | 12b. KIND OF BUSINESS OR INDUSTRY
Md. Rehab.Cntr. | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Harford | | | 13c. CITY OR TOWN
Havre de Grace | | | 13e. STREET ADDRESS
712 Alliance Street | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carl W. Easton, Sr. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Willettta Sharon | | | | | ADDRESS
712 Alliance Street
Willettta S.Hines Havre de Grace, Md. | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | 16b. SOCIAL SECURITY NO.
212-48-6634 | | | | | 17. INFORMANT
ADDRESS
712 Alliance Street
Willettta S.Hines Havre de Grace, Md. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ventricular tachyarrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>hypotension, pressor dependence</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>multisystem organ failure, sepsis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 sec.</u>
<u>4 days</u>
<u>2 weeks</u> | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>s/p perforated duodenal ulcer</u> | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>3/9/82</u> | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>perforated ulcer</u> | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>82</u> to <u>5/1</u> 19 <u>82</u> , that (II) (we) lost
saw the deceased alive on <u>5/1</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Timothy G. Buchman MD</u> | | | | | | | | | | DEGREE
MD | | 22c. DATE SIGNED
<u>5/1</u> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TIMOTHY G. BUCHMAN | | | | | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | | 23b. DATE
May 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
West Nottingham | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cecilia Maryland | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Lee A. Patterson</u> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 6 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Lee A. Patterson</u> | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the earliest opportunity.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 1 9 9 7 | |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR WILLIAM EBERLING | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | |
| FIRST <u>William</u> MIDDLE <u>Joseph</u> LAST <u>Eberling</u> | | | | MONTH <u>May</u> DAY <u>14</u> YEAR <u>1982</u> HOUR <u>12</u> MIN. <u>18</u> AM <u>A</u> | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH | |
| MONTH <u>Sept.</u> DAY <u>28</u> YEAR <u>1909</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNION MEMORIAL HOSPITAL</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Owner</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Monument Co.</u> | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | |
| 14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>Rudolph</u> LAST <u>Eberling</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>Winfred</u> LAST <u>Mulcahy</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>220-09-9886A</u> | | 17. INFORMANT <u>Widow:</u> ADDRESS <u>Elizabeth H. Eberling, 605 Lennox St. 21217</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE / CHR. OBST. PULM. DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Cerebrovascular Accident</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR <u></u> A.M. <u></u> MONTH <u></u> DAY <u></u> YEAR <u>19</u> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u> | |
| 22a. I certify that I (this hospital) attended the deceased from <u>April 12</u> , 19 <u>82</u> , to <u>May 14</u> , 19 <u>82</u> , that I (we) last saw the deceased alive on <u>May 13</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Charles W. Hicks III</u> | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>5-14-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles W. Hicks III</u> | | 22e. ADDRESS <u>c/o UNION MEMORIAL Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/17/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | |
| 24. FUNERAL DIRECTOR <u>Stewart & Mowen</u> | | 24a. ADDRESS <u>108 W. Northline</u> | | 24b. DATE REC'D. BY REGISTRAR <u>MAY 19 1982</u> | |
| 24c. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | 24d. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 9 8

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Louis E. Eder | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-16-82 | | | 2b. HOUR
2:32 PM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-7-17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTO. CITY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Eder | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Swisher | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
Yes W.W. II | | | |
| 16b. SOCIAL SECURITY NO.
215-10-2021 | | | 17. INFORMANT
ADDRESS
ANNA P. EDER-3604 Hudson St. #21224 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest Followed by Cardiac Arrest
4349
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral Herniation
DUE TO, OR AS A CONSEQUENCE OF
(c) Hemorrhagic Cerebral Infarct & Large Hematoma
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
History of Hypertension, Deceased Had Stopped Taking Medicines. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 6th, 1982 , to May 16th, 1982 , that (we) last saw the deceased alive on May 15, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alex Kosenko | | | DEGREE
III | | | 22c. DATE SIGNED
5/16/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALEXANDER KOSENKO | | | 22e. ADDRESS
Lawrence R. Bell 3001 S. HANOVER ST. BKT MD 21230 | | | 22f. REGISTRAR'S SIGNATURE
George A. Weber | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
5/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. STANISLAUS CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | |
| 24. FUNERAL DIRECTOR
NAME
GEORGE A. WEBER & SONS INC. | | | ADDRESS
705 S. ANN ST. | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. ... | |

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Yes, it is a very good idea.

Yes, it is a very good idea.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 9 9 9

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BERTRAM Edmonds | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-10-82 | | | 2b. HOUR
8:50 PM | | | | |
| 3. SEX
male | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 1, 1958 | | 6. AGE (IN YEARS LAST BIRTHDAY)
23 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALB. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
BALB. | | 13c. CITY OR TOWN
BALB. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1603 Bruce Ct. Apt 8 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Edmonds | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
213-70-0791 | | 17. INFORMANT
ADDRESS
Mrs. Sarah Edmonds 1603 Bruce Ct. Apt 8 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
5860
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) renal failure
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: D.M., A.D.S.S. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 82 to May 19 82 , that (I) (we) lost
saw the deceased alive on April 8 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Hector K. Collison DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
10/5/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HECTOR K. COLLISON MD. | | | | | | 22e. ADDRESS
PROVIDENT HOSP. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(BY)
BURIAL | | | 23b. DATE
5-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Hubert Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALB. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph L. Russ 2222 W. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1982 | | | | |
| 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | | | | | | | | |

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Items 19b. Film#G568

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 0 0

1- FOR STATE REGISTRAR
6-25-82 AL

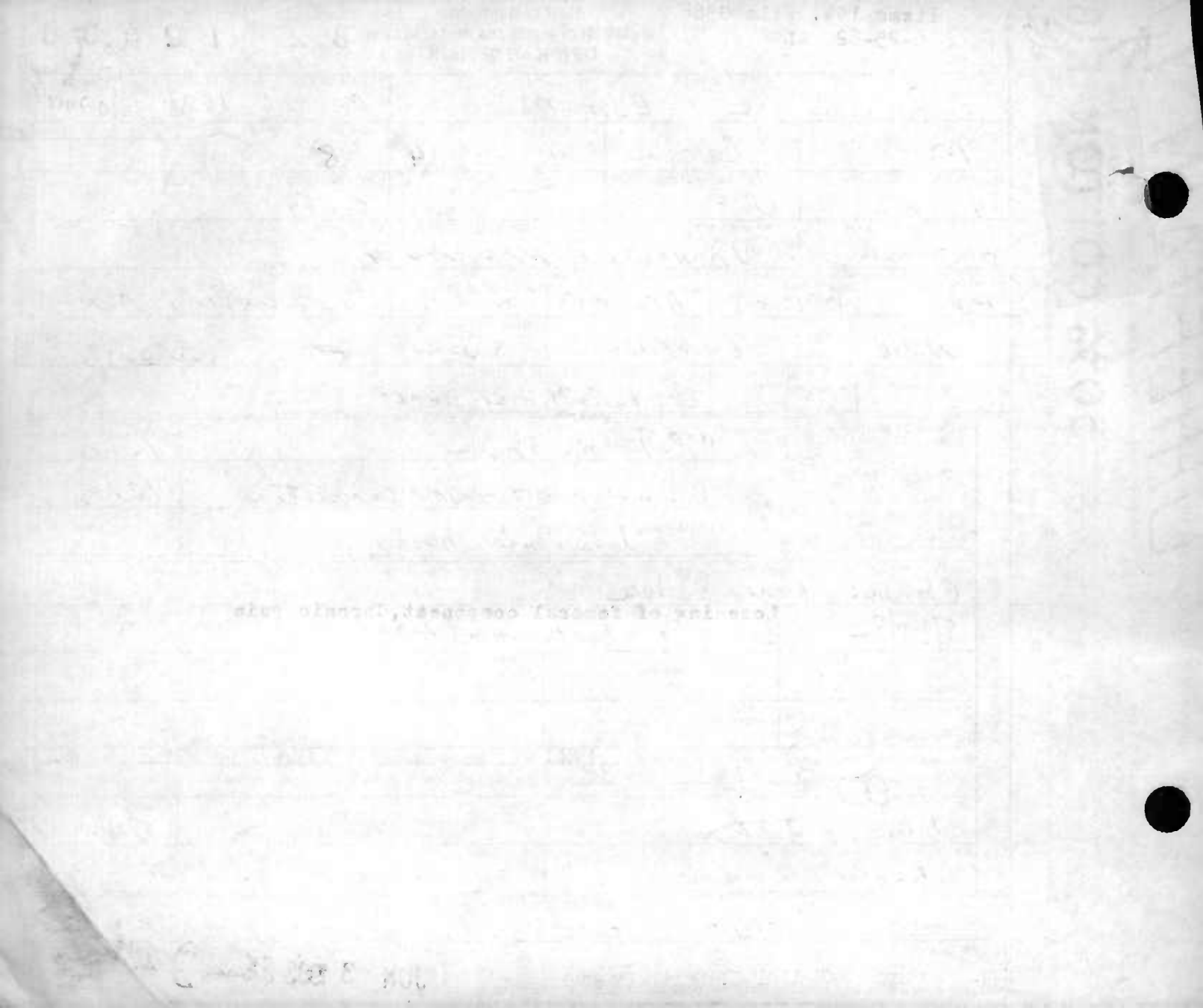
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Richard L Edmonds | | | 2a. DATE OF DEATH
MONTH MAY DAY 26 YEAR 1982 | | | 2b. HOUR
0744 ^A _M | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 01 DAY 03 YEAR 34 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
48 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MD. | |
| 13a. STATE
MD | | 13b. COUNTY
BALT CITY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Willie MIDDLE Edmonds LAST Edmonds | | 15. MOTHER'S MAIDEN NAME
FIRST Susan MIDDLE Vough LAST Vough | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
224 40 8674 | | 17. INFORMANT
HOSP. CHART ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypovolemic shock
286b
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Disseminated Intravasc. Coagulation
(c) disseminated bleeding | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 hrs
12 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic Renal Failure | | | | | | | |
| 19a. DATE OF OPERATION
5/25/82 | | 19b. LOSS OF OR WHICH LIMB OR LIMBS? lossening of femoral component, Chronic pain
Left Total Hip Replacement (LEPAT) | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/23 , 19 82 , to 5/26 , 19 82 , that (I) (we) lost saw the deceased alive on 5/26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
S. Howard | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BATHUN, S. Howard | | | | 22e. ADDRESS
22 S. GREENE ST BALTIMORE MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
6/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If you may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|--|--|---|--|-------------------------|--|--------------------------|--|-------------|--|------|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Roy | | CARLYLE | | Edmonds | | JR. | | XX | | 5 | | 1 | | 1982 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | 9 - 7 - 1960 | | 21 YRS. | | | | | | 5 | | 1 | | 1982 | | 3:10 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| MARYLAND | | U.S.A. | | | | Baltimore City, | | MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | University Hospital - STU | | CARPENTER | | CONTACTING | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MARYLAND | | BALTIMORE | | DUNDALK | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 274 COLGATE AVE. | | 21222 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| ROY | | BARBARA | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 220.74.1659 | | ROY C. EDMONDS SR. | | SAME AS 13e | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Complications of compartment syndrome</u> | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | |
| (b) <u>(arms) due to drug-induced coma</u> | | | | | | | | | | | | | | | | | |
| (c) <u>(probable PCP)</u> | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on <u>(head only)</u> <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | |
| Virginia L. Dolan | | M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | 5-2-82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| BURIAL | | 5/4/1982 | | GARDENS OF FAITH CEM. | | BALTO. | | MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | | |
| NAME | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| WALTER BROOKS BRADLEY, INC. | | MAY 4 1982 | | | | | | | | | | | | | | | |
| DUNDALK, MD. 21222 | | James J. Nathan | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

20% COTTON FIBER

100% COTTON FIBER



Handwritten signature or text, possibly "L. J. ..."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 212-635-1234.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 0 2

REG. NO.

| | | | | | | | | |
|--|---|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF BIRTH | | | 2b. HOUR | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ADA EDWARDS | | | 5/22/82 | | | 6:25 P.M. | | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH 09 DAY 10 YEAR 1907 | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. COUNTY BALTO. | | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 14. FATHER'S NAME
FIRST ALPHONSO MIDDLE BOWIE LAST BOWIE | | | 15. MOTHER'S MAIDEN NAME
FIRST ROSE MIDDLE WINDSOR LAST GARDENS LANE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
220-22-7670 | | 17. INFORMANT
ADDRESS Alphonso Bowie 3016 Rockwood Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1790
IMMEDIATE CAUSE (a) R/O PE (pulmonary embolism)
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC CA. FROM UTERINE
DUE TO, OR AS A CONSEQUENCE OF
(c) + VAGINAL CA.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
THROMBOPHLEBITIS | | | | | | | | |
| 19a. DATE OF OPERATION
5/14/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
R/O METASTATIC CA. | | | 20a. AUTOPSY?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22/1982 19 1902 , that (I) (we) lost 5/22/1982 19 1902 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Menahem Abraham, M.D. | | | | DEGREE | | 22c. DATE SIGNED
5/25/82 | | 22d. SIGNATURE
Menahem Abraham, M.D. |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
MENAHAM ABRAHAM, M.D. | | | | 22f. ADDRESS
SINAI HOSPITAL - BALTIMORE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CO. MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME Nancy M. Wallace ADDRESS 3405 W. FRANKLIN ST. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 25 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Smith | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|----|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

12-12-2000

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Item #17 Film G567 5/20/82 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5212003

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LAWRENCE W. EFFORD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 10, 82 | | | 2b. HOUR
4 p-m | | | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 16, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4414 Marble Hall Road #333 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Reporter | | 12b. KIND OF BUSINESS OR INDUSTRY
Sunnappers | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4414 Marble Hall Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John S. Efford | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I 223 22 4740 | | 17. INFORMANT
Dorothy Mrs. Doris F. Efford, Same | | | ADDRESS | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute coronary ood.</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>atherosclerotic cardiovascular Dis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>MIN</u>
<u>YRS</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Remote CVA - Chronic Atrial Fibrillation</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1-6-</u> 19 <u>78</u> , to <u>5-10-</u> 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>5-10-</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u>
DEGREE | | | | | | 22c. DATE SIGNED
5-10-82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. J. VENABLE JR M.D. | | | | | | 22e. ADDRESS
7215 York Rd - Baltimore MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Farnham Bapt. Ch. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Farnham, Va. | | | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., Md. 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1982 | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
obtained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept.
of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2017, 1, 22

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7a g567 5/27/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 0 4

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Albert G. Eichelberger | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 17 82 | | | 2b. HOUR
7am | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 21 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Good Samaritan Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Plaster/Concr. Sinaia Hosp | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
md | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3946 Hickory Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Eichelberger | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Linsmar | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
ADDRESS
Eunice Eichelberger-3946 Hickory Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic failure
DUE TO, OR AS A CONSEQUENCE OF (b) Extrahepatic obstruction
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic adenocarcinoma-unknown origin
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1991
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
1 week
1 year | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Diffuse intra-abdominal and gastrointestinal hemorrhage | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 19 81 to May 17, 19 82 , that (I) lost saw the deceased alive on May 16, 19 82 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Paul Chang, MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
5/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul Chang, MD | | | | 22e. ADDRESS
Good Samaritan Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem Gdns | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Towson, Balto Co, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1982 | | 25b. REGISTRAR'S SIGNATURE
Roland A. | | | |

1 2 3 4 5

Albert A. Einstein

United States of America

Washington, D.C.

Department of the Interior

Division of Reclamation

Washington, D.C.

Mr. E. A. Tamm

U.S. Supreme Court

Washington, D.C.

Dear Mr. Justice:

I am very pleased to hear from you.

I am sure you will find the enclosed of interest.

I am, very respectfully,

Yours very truly,

John D. Rockefeller

Enclosure

Very truly yours,

John D. Rockefeller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 0 5 | | | |
|--|--|--|--|--|--|---|--|--|--|---|-----|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Katherine | | Eiler | | | | | | 5 | | 16 | 82 | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS | | | |
| female | | white | | 12 6 01 | | 80 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | USA | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Baltimore City Hospital | | | | | | | | house-wife | | home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 612 Macon Street | | 21224 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | |
| Conrad | | Hettechen | | Katherine Malkus | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| no | | 212 74 6403 | | Edward Eiler | | 612 S. Macon Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>chronic arteriosclerosis</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/29</i> , 19 <i>78</i> , to <i>5/16</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>4/18</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | | | 22c. DATE SIGNED | | | |
| <i>John B. Dabrowski, MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | <i>5/17/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| J.B. DABROWSKI, M.D. | | 3508 BAY ST. - Baltimore, Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| Burial | | 5/20/82 | | Oak Lawn | | Baltimore | | COUNTY STATE Md | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| NAME | | MAY 19 1982 <i>James J. Dabrowski</i> | | | | | | | | | | | |
| Walter Dabrowski | | 1005 Dundalk Avenue | | | | | | | | | | | |

Walter Dabrowski

5/20/82

Gen. Inv.

Baltimore

10

no

212 74 6403

Edward Miller 212 S. Mason Street

Conrad

Hetherton

Katherine

Melina

Maryland

Baltimore

x

2122A 2122A

Baltimore

Baltimore City Hospital

house-wife

home

Maryland

USA

x

Baltimore City

female

white

12

01

80

Katherine

Miller

2 12 82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-1111.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 0 6 | |
|--|--|---|--|---|--|---|--|--|--|------------------|--|
| FOR
1. STATE
REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Otto William Einolf | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/21/82 | | | 2b. HOUR
11 a.m. | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 25 98 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Policeman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. City | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY --- 13c. CITY OR TOWN Baltimore | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3709 Coolidge Avenue, 21229 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Einolf | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Wilhelmina Flick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
218-34-0901 | | 17. INFORMANT ADDRESS
Donald Einolf 906 Pine Heights Ave., 21229 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest 2^o to ventricular fibrillation</u>
4274
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-20-1982</u> to <u>5-21-1982</u> , that (I) (we) last saw the deceased alive on <u>5-21-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Mallin | | | | DEGREE | | | | 22c. DATE SIGNED
5-21-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Mallin | | | | 22e. ADDRESS
Box 81 - Agnes Hospital - Balto 900 Cedar Ave - Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Entombment | | 23b. DATE
05-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 24b. ADDRESS
21229 | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas Jan... | | | |

Notes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 2 0 0 7 | |
|---|--|---|--|--|--|
| 1. NAME
FIRST MIDDLE LAST
William P EISENHARDT | | CERTIFICATE OF DEATH
REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX
Male | | 2a. DATE OF DEATH MONTH DAY YEAR
5/18/82 | |
| 2b. HOUR
10:00 AM | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov 2 1905 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
assembler | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Western Electric | | 13a. STATE
Maryland | | 13b. COUNTY
--- | |
| 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1125 Cleveland St. 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Chris Eisenhardt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Emma Simmons | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes / Coast Guard 1931 | | 16b. SOCIAL SECURITY NO.
215-10-0664 | | 17. INFORMANT ADDRESS
Effie Berry/309 S Norris St/Balto Md 21223 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
1850
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Disseminated Prostatic Carcinoma</u>
(c) <u>6 months</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>82</u> , to <u>May 18</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>May 17</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Edward J. Beaman MD</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BEAMAN | | 22e. ADDRESS
University Hospital, Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
05/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge/Howard Co./ Maryland | | 24. FUNERAL DIRECTOR
NAME
Walters Funeral Home/Pratt & Stricker Streets | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1982 | |
| 25b. REGISTRAR'S SIGNATURE
<u>Barbara Jean Nathan</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

| 1. FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 0 8 | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Edmund WILLIAM Eldridge, Sr. | | | | 05/28/82 | | | | 3:40 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS. | |
| Male | | White | | Jan. 1, 1909 | | 73 | | MONTHS | | DAYS | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Baltimore City Hospitals | | | | Salesman | | Beth. Steel | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5527 Daywalt Ave. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Lemuel Gilbert Eldridge | | | | Elizabeth Hopwood | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes | | | | WW II | | Ruth Eldridge, 5527 Daywalt Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | | |
| 4100 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) SUDDEN DEATH SYNDROME | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 5/27/82, 19 82, to 5/28, 19 82, the (1) (we) lost saw the deceased alive on 5/28, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If the doctor did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| Gordon Raphael | | | | | | | | | | 5/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| GORDON RAPHAEL | | | | BALTIMORE CITY HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | June 1, 1982 | | Gardens of Faith | | City or Town County State | | | | | |
| | | | | | | Overlea Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214 | | | | | | JUN 2 1982 | | Ruth Eldridge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ELIZABETH SUSAN

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 show evidence of other traumatic event, threatened violence against child, brother, sister, spouse,

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 0 9

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (LAST, FIRST, MIDDLE, AND SUFFIX)
(TYPE OR PRINT) | | 2. (AKA Christle Ann) Susan | | 3. LAST
Eli | | 4. DATE OF DEATH
MAY 15, 1982 | | 5. HOUR
11:05a | |
| 6. SEX
Female | | 7. RACE
Caucasian | | 8. DATE OF BIRTH
9-26-81 | | 9. AGE (IN YEARS LAST BIRTHDAY)
7mo.22 days | | 10. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 14. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 15. CITY OR TOWN OF DEATH
Balto. | | 16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
none | | 18. KIND OF BUSINESS OR INDUSTRY
none | | | |
| 19. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. Prince Georges County | | 20. CITY OR TOWN
Laurel | | 21. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 22. STREET ADDRESS
9757 Washington Blvd. Rt. 1 | | | |
| 23. FATHER'S NAME
Thomas Eli | | 24. MOTHER'S MAIDEN NAME
Mary Marks | | 25. WAS DECEASED EVER IN U.S. ARMED FORCES?
no | | 26. SOCIAL SECURITY NO.
ADDRESS
Laurel, Md.
Steve Eli 9757 Washington Blvd. Rt. 1 | | | |
| 27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic Shock
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | 28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
6 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 29. DATE OF OPERATION | | 30. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 31. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 32. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 33. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 34. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 36. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 37. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 38. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 39. I certify that (I) (this hospital) attended the deceased from May 11, 1982, to May 15, 1982, that (I) (we) last saw the deceased alive on May 15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 40. SIGNATURE
Richard D. Wayne MD | | 41. DEGREE
MD | | | | 42. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 43. DATE SIGNED
5/15/82 | |
| 44. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard D. Wayne MD | | 45. ADDRESS
The Johns Hopkins Hospital | | | | | | | |
| 46. BURIAL, CREMATION, REMOVAL
SPECIFY | | 47. DATE | | 48. NAME OF CEMETERY OR CREMATORY | | 49. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | 5-18-82 | | Louden Park Cem. | | Balto., Md. | | | |
| 50. FUNERAL DIRECTOR
NAME | | 51. DATE REC'D. BY REGISTRAR | | 52. REGISTRAR'S SIGNATURE | | | | | |
| Schimunek Funeral Home, Inc.
3331 Brehms Lane 21213 | | MAY 18 1982 | | Francis J. [Signature] | | | | | |



NOT
TO
BE
REPRODUCED
WITHOUT
PERMISSION
OF THE
OFFICE

1961
1962

ELSASSER, SUSANNE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
RELEASED AS NON MED BY DR THOMAS SMITH

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 82 12010

| | | | | | | |
|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SUSANNE A. ELSASSER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 11 82 | | 2b. HOUR
123 P M | |
| 3 SEX
female | | 4 RACE
white | | 5 DATE OF BIRTH
MONTH DAY YEAR
June 3, 1912 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6 AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
home | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fritz. Rosenfeld | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Toni Lublinski | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
100 12 1309 | | 17 INFORMANT
Walter M. Elsasser Baltimore, Md. 21210 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic Ovarian cancer
1830
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 81 , to 5/11 , 19 82 , that (I) (we) last saw the deceased alive on 5/11 , 19 82 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
J B Lefkowitz | | DEGREE
MD | | 22c. DATE SIGNED
5/11/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J B Lefkowitz MD | | 22e. ADDRESS
Johns Hopkins Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
cremate | | 23b. DATE
5/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Park | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, Balto. Maryland | | 24 FUNERAL DIRECTOR
NAME ADDRESS
BLACK Funeral Home, Ellicott City, Maryland 21043 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | REGISTRAR'S SIGNATURE
James J. Smith | | | | |

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



NOTED

RECEIVED MAY 17 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLES F. ENGEL | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/3/82 | | 2b. HOUR
6³⁰ A.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 18 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Butcher | | 12b. KIND OF BUSINESS OR INDUSTRY
Armour & Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
310 Oaklee Village 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frederick Engel | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emelia Dudeck | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-0426 | | 17. INFORMANT ADDRESS
Dorothy E. Engel 310 Oaklee Village 21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic Carcinoma
1991
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Asc'd renal failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (if (this hospital) attended the deceased from 4/12/82 , 19 82 , to 5/3/82 , 19 82 , that (I) (we) last saw the deceased alive on 5/2/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Cornelius Halma, M.D. | | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Cornelius Halma, M.D. | | | | | 22e. ADDRESS
St. Agnes Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cemetery | | 23d. LOCATION
CITY OR TOWN STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | 25a. DATE BY REGISTRATION
MAY 6 1982
James J. Martin | | | | |

2/13/52



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 2 0 1 2 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT ELMER ENGLISH | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 2 82 | | | |
| 3. SEX Male | | | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 10, 1925 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mailhandler | | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Off. | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Curtis English | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Roberts | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW II 184-20-0593 | | 17. INFORMANT ADDRESS Dorothy J. English, 4506 Weitzel Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ventricular fibrillation
DUE TO, OR AS A CONSEQUENCE OF
(b) inferior wall myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) coronary artery disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minutes
8 hours
years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diabetes mellitus, chronic obstructive pulmonary disease | | | | | | | |
| 19a. DATE OF OPERATION 5/2/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED inferior myocardial infarction | | 20a. AUTOPSY? error YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2, 1982 , to 5/2, 1982 , that (I) (we) lost saw the deceased alive on 5/2, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE P Dubyoski MD | | | | DEGREE | | 22c. DATE SIGNED 5/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DUBYOSKI | | | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 5, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 | | 25b. REGISTRAR'S SIGNATURE Theresa Jan... | |
| 6009 Harford Rd., Balto., Md. 21214 | | | | | | | |

1987

WASHINGTON CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

4000 W. 10th Ave.

Baltimore

Maryland

English

English

134-20-0012 8 books

WM 21

WM 21

X X

UNION MEMORIAL HOSPITAL

MAY 2 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 8212013 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Mary E. Enos | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 26, 1982 | | 2b. HOUR
5:45 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 30, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4710 Harford Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4710 Harford Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Feeney | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Edith Horning | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
219-18-0636 | | 17. INFORMANT ADDRESS
Edward S. Enos 4710 Harford Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Liver failure
5715 DUE TO, OR AS A CONSEQUENCE OF (b) Advanced liver cirrhosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days
years. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Gracito Patricio, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gracito Patricio, M.D. | | | | 22e. ADDRESS
703 S. Clinton St. Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
May 28, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
22 Green Mount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 28 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

15013

5



100% COTTON FIBER

Handwritten text, possibly a signature or date, in the center of the page.

Handwritten text at the bottom left corner, possibly a date or signature.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 1 4 | |
|--|--|---|--|---|---|---|---|---|---|---|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Samuel C Epps | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR May 4 82 | | 2b. HOUR
7:45 M | | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR 08 29 35 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 72 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
C 157. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Contractor | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md | | | 13b. COUNTY
Balt. | | 13c. CITY OR TOWN
Balt. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4111 Springdale Ave | | |
| 14. FATHER'S NAME
Calloway C. Epps | | | | | 15. MOTHER'S MAIDEN NAME
Estelle Johnson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES
(YES, NO OR UNKNOWN) 460 | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
Estelle Epps | | | ADDRESS
4111 Springdale Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF
1734
DUE TO, OR AS A CONSEQUENCE OF
(b) HEAD & NECK
DUE TO, OR AS A CONSEQUENCE OF
(c) RESPIRATORY INSUFFICIENCY | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from NOV 81 , to MAY 82 , that (I) (we) last saw the deceased alive on 30 APR 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. L. Luxer | | | | | | DEGREE
BCRC | | 22c. DATE SIGNED
5-4-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. L. Luxer | | | | | | 22e. ADDRESS
BCRC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Int. Calvary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
B. L. County Md | | | | |
| 24. FUNERAL DIRECTOR
NAME
Lock Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1982 | | 25b. REGISTRAR'S SIGNATURE
Anna Jan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

item 15 #G568 6/24/82 ph

FOR
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 1 5
REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
SHIRLEY C EPPS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05-16-82 | | | 2b. HOUR
10:17 PM | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
01-10-39 | | 6. AGE (IN YEARS LAST BIRTHDAY)
43 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALT. GEN. HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
CITY | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM J EPPS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARION JOHNSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Bernadette Armstrong 2614 Kent St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
<u>4939</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>LOBAR PNEUMONIA, MASSIVE, RIGHT LUNG</u>
<u>PULMONARY EMBOLISM (By Aut. Pathologist)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASTHMA, ANGINA, HBP</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> 19 <u>82</u> to <u>5-16</u> 19 <u>82</u> that (I) (we) lost
saw the deceased alive on <u>5-18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Alex Kosenko | | DEGREE | | 22c. DATE SIGNED
5-16-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALEXANDER KOSENKO | | 22e. ADDRESS
3001 S. HANOVER ST. BLT MD 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn | | 23d. LOCATION
CITY OR TOWN COUNTY
Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME
VERNON BALLEY | | ADDRESS
1348 CALHOUN ST | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAY 24 1982 James J. [Signature] | | | |

MADE IN U.S.A.

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Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 2 10 1 6
REG. NO. | | | |
|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) IRENE ERKES | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 27 '82 | | 2b. HOUR
11:10 A M | |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
5 18 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL OF BALTIMORE | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESLADY | | 12b. KIND OF BUSINESS OR INDUSTRY
SHOES | |
| 13a. STATE
MARYLAND | | | | 13b. CITY OR TOWN
BALTO. | | 13c. STREET ADDRESS
3518 COURTLEIGH DR. #21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LOUIS SHERRY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA POTTS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-01-0073 | | 17. INFORMANT
NAME ADDRESS
MEYER ERKES
3518 COURTLEIGH DR. BALTO., MD 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SLOW INCREASE IN INTRACRANIAL PRESSURE
DUE TO, OR AS A CONSEQUENCE OF
(b) BRAIN METASTASES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) OAT CELL CANCER OF LUNG.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS
2 MONTHS
2 MONTHS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10 , 19 82 , to 5-27 , 19 82 , that (I) (we) last saw the deceased alive on 5-27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Jim | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5-27-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. LIM | | 22e. ADDRESS
SINAI HOSPITAL, BALTIMORE, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAY 30, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 4 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | | | | 8 2 1 2 0 1 7
CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| Stephen C. Ervin, Jr.
BABY BOY BROWN | | | | | MAY 30, 1982 | | | | | |
| 3 SEX
Male | | | | | 4 RACE
Black | | | | | |
| 5. DATE OF BIRTH
5 27 82 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 3 MONTHS 5 HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
JOHNS HOPKINS HOSPITAL | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MD | | | | | 13b. CITY OR TOWN
Baltimore | | | | | |
| 14. FATHER'S NAME
Stephen C. Ervin Sr. | | | | | 15. MOTHER'S MAIDEN NAME
Patricia L. Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
N/A | | | | | |
| 17. INFORMANT
Patricia Brown | | | | | ADDRESS
813 N. Washington St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
7468
DUE TO, OR AS A CONSEQUENCE OF
(b) HYPOPLASTIC LEFT HEART
32.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 minute | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27 19 82, to 5/30 19 82, that (I) (we) lost
saw the deceased alive on 5/30 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
David M. Virshup MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
5/30/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID M VIRSHUP | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
6/2/82 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1982 | | | | |

1331A

Handwritten notes and calculations, including a table with columns for 'Time' and 'Distance'.

| Time | Distance |
|-------|----------|
| 1.00 | 1.00 |
| 2.00 | 2.00 |
| 3.00 | 3.00 |
| 4.00 | 4.00 |
| 5.00 | 5.00 |
| 6.00 | 6.00 |
| 7.00 | 7.00 |
| 8.00 | 8.00 |
| 9.00 | 9.00 |
| 10.00 | 10.00 |

Handwritten notes and calculations, including a table with columns for 'Time' and 'Distance'.

| Time | Distance |
|-------|----------|
| 1.00 | 1.00 |
| 2.00 | 2.00 |
| 3.00 | 3.00 |
| 4.00 | 4.00 |
| 5.00 | 5.00 |
| 6.00 | 6.00 |
| 7.00 | 7.00 |
| 8.00 | 8.00 |
| 9.00 | 9.00 |
| 10.00 | 10.00 |

Vertical text on the right margin, possibly a page number or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

| Item 13e per phone 6/14/82 dad STATE OF MARYLAND | | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|--|---|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HELEN B EVANS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 31, 1982 | | | | | 2b. HOUR 1:10p.m. |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5 13 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) North Car. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS long term res. of hospital Broadway & Fayette Sts. |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jessie Bradley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madline | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 220 14 0318A | | 17. INFORMANT ADDRESS James Evans 2602 Roslyn Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST | | | | | | | | | | |
| 1539 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA COLON WITH METASTASIS | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-31 , 19 82 , to 5-31 , 19 82 , that (I) (we) last saw the deceased alive on 5-31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Y.K. SHETTY DEGREE | | | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Y.K. SHETTY | | |
| 22e. ADDRESS 100 North Broadway Baltimore, Md 21231 Church Hospital Corporation | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR NAME Leroy O Dyett ADDRESS 4406 Liberty | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1982 REGISTRAR'S SIGNATURE James J. [Signature] | | | | | |

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
125 WEST 47TH STREET
NEW YORK 10018



1. The first part of the book is devoted to a general survey of the history of the world from the beginning of time to the present day. It is written in a clear and concise style, and is suitable for use as a text-book in schools and colleges. The second part of the book is devoted to a detailed account of the history of the United States from the time of the first settlement to the present day. It is written in a clear and concise style, and is suitable for use as a text-book in schools and colleges. The third part of the book is devoted to a detailed account of the history of the British Empire from the time of the first settlement to the present day. It is written in a clear and concise style, and is suitable for use as a text-book in schools and colleges.

NOT A BOOK



1. The first part of the book is devoted to a general survey of the history of the world from the beginning of time to the present day. It is written in a clear and concise style, and is suitable for use as a text-book in schools and colleges. The second part of the book is devoted to a detailed account of the history of the United States from the time of the first settlement to the present day. It is written in a clear and concise style, and is suitable for use as a text-book in schools and colleges. The third part of the book is devoted to a detailed account of the history of the British Empire from the time of the first settlement to the present day. It is written in a clear and concise style, and is suitable for use as a text-book in schools and colleges.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 1 9

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|---|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Willie T. Ewell | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-25-82 | | | 2b. HOUR
M | | | | | |
| 3. SEX
M | | 4. RACE
Blk | | 5. DATE OF BIRTH
MONTH DAY YEAR
6-30-02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
9 N. Catherine St. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | 13b. COUNTY
— | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9 N. Catherine St. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Ewell | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Wessells | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-03-4766 | | 17. INFORMANT
Rosie Sumler | | | | ADDRESS
9 N. Catherine St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CA 7 Lung -
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Holmes & Narver | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MENA A SARRAN | | | | | | 22e. ADDRESS
An der ... | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
5-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Methodist Cem | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pasley VA | | | |
| 24. FUNERAL DIRECTOR
NAME
Vernon R. Bailey | | | | | | ADDRESS
1348 N. Calhoun St | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1982 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
James J. ... | | | | | |

13 MAY 1985

13 MAY 1985



MAY 13 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 2 0
REG. NO. | | | | | |
|--|--|--|--|--|---|---|---|--|--|---|--|---|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ELMER BYRON FARMER | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 7 82 | | | | 2b. HOUR
12:20AM | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
3 30 21 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 | | | 7. IF UNDER 1 YEAR MONTHS DAYS
YRS. | | 8. IF UNDER 24 HRS. HOURS MIN.
YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven VAMC | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | | 12b. KIND OF INDUSTRY OR CONVERSION
Marine Conversion | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
1036 Hignet Way | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Rob Roy Farmer | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nora Combs | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
WW II | | | 17. INFORMANT
Deborah J. Farmer | | | ADDRESS
1036 Hignet Way Balto., MD. 21205 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Pneumomonias - end stage lung disease | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOI WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from APRIL 22, 19 82 , to MAY 7, 19 82 , that X (we) last saw the deceased alive on MAY 7, 19 82 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE G Grolean MD DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
5/7/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G Grolean MD | | | | | | 22e. ADDRESS
3900 Loch Raven Blvd Balto., Md. 21218 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
5/10/1982 | | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Duda-Ruck, Inc. | | | | | | ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | | 25a. DATE REC'D. BY REGISTRAR
MAY 10 1982 | | 25. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | |

Letter

To: Mr. [illegible]

From: [illegible]

Subject: [illegible]

Date: [illegible]

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 2 1 | | | |
|--|--|---|--|--|--|--|--|
| FOR
1. STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(TYPE OF NAME) | | | | 2a. DATE OF DEATH | | | |
| L. Ann James Brown Zarrow | | | | 5 7-82 3:15 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | |
| Female | | Black | | 8 16 18 | | 63 | |
| 7a. BIRTH PLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Greenfield, Mo | | USA | | NEVER MARRIED | | Baltimore city | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Poplar Minor Nursing Home | | Domestic | | | |
| 13a. USUAL RESIDENCE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md | | | | City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES | | 17. SOCIAL SECURITY NO. | |
| Wilton | | Mary Jones Zarrow | | no | | 248-387090 | |
| 18. CAUSE OF DEATH | | 19. DATE OF OPERATION | | 20. AUTOPSY? | | 21. INJURY OCCURRED | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary arrest.
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD - Diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | | 19c. HOW INJURY OCCURRED | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | 21b. TIME OF INJURY | |
| | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | HOUR A.M. MONTH DAY YEAR | |
| | | | | | | P.M. 19 | |
| | | 21f. LOCATION | | 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | |
| | | STREET CITY OR TOWN COUNTY STATE | | 3-14-1982 to 5-7-1982 | | K. NAIR, M.D. | |
| | | | | saw the deceased alive on 5-7-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22c. DATE SIGNED | |
| | | | | | | 5-8-82 | |
| | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | |
| | | | | Burial | | 31382 | |
| | | | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| | | | | Mt Zion | | Baltimore Md | |
| | | | | 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | |
| | | | | Melba L. McQuinn | | MAY 10 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | Francis Jan. Warren | | | |

1250

Item 6 g568 6/1/82 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 2 2

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ameel Faulcon | | | 2a. DATE OF DEATH
MONTH DAY YEAR 5 14 1982
HOUR 12 M | | |
| 3. SEX
Female | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR 6 - 3 - 11 | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | |
| 10. CITY OR TOWN OF DEATH
Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Penn Ave N.H. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | | 13b. COUNTY | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfred J. Booker | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Mitchell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Joseph Booker 548 Fulton Ave | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Adeno Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) 1991
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4-15-82 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Seizure Disorder. | | | | | |
| 9a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IE EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-3-82 , to 5-14-82 , that (I) (we) lost
saw the deceased alive on 5-14-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Shaukat | | DEGREE
MD | | 22c. DATE SIGNED
5-14-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHAUKAT Y. KHAN | | 22e. ADDRESS
1528 KING WILLIAM DRIVE, BALTO, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY Burial | 23b. DATE
5/19/82 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto MD | |
| 24. FUNERAL DIRECTOR
NAME
VERNON BALIEY | | ADDRESS
1348 CALHOUN ST | | 25a. DATE REC'D. BY REGISTRAR
MAY 24 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Phane. Van Thien | |

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100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100



100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 2 3

REG. NO.

| | | | | | |
|---|---------------------|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN FELDER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5-12-82 | | 2b. HOUR
M |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
9 17 32 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3118 GWYNNS FALLS PARKWAY | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM SMITH | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
DOROTHY HARRIS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-28-4721 | | 17. INFORMANT
ADDRESS
WILLIE FELDER 3118 GWYNNS FALLS PKY. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
1830 DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC OVARIAN CANCER.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
N/A | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/30 19 82 to 4/27 19 82 , that (I) (we) last saw the deceased alive on 4/28 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
E. Hernandez | | DEGREE
MD | | 22c. DATE SIGNED
5/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. Hernandez | | 22e. ADDRESS
Division Gyn Oncology
600 N. Wolfe BALTO. MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
5-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. NAT. MEM. PK. | |
| 24. FUNERAL DIRECTOR
NAME
E.L. PHILLIPS | | 1721 N. MONROE ST. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LAUREL MARYLAND | |
| 25a. DATE REC'D. BY REGISTRAR
MAY 21 1982 | | 25b. REGISTRAR'S SIGNATURE
Van Natta | | | |

0 2 0 2 1 2 6

SALES
ST. LOUIS, MO.
JULY 1914

51.0

SECTION 10



W. S. L. AS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

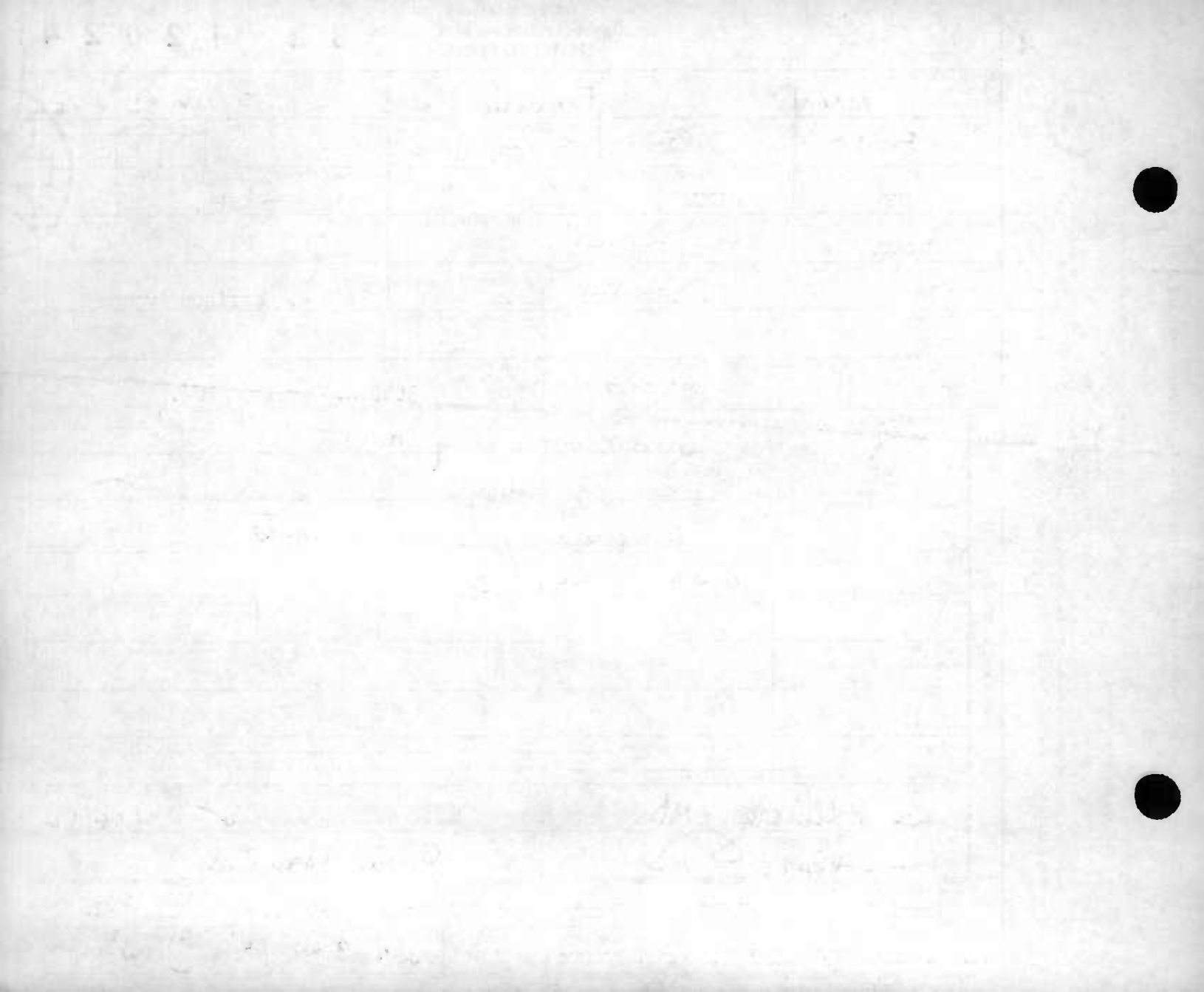
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 2 0 2 4

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 5 26 82 | | 6:15 am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Black | | MONTH DAY YEAR
12 28, 1905 | | 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| NY | | USA | | | | Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Sinai Hospital | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Unkn | | Unkn. | | No | | 213-74-7265 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Mary Cary | | 3809 W. Garrison Ave. | | IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u> | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI Bleeding.</u> | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the colon & mets.</u> | | | |
| | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHF, Aneurysm.</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| | | Jose R Alvarez MD | | | | 5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Jose R Alvarez MD | | Sinai Hospital | | Burial | | 6/1/82 | |
| | | | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| | | | | Sacred Heart Of Jesus | | Balto., COUNTY MD. STATE | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 1101 E. North Avenue | | JUN 3 1982 | | [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 2 5 | |
|--|--|---|--|--|--|--|--|---|---|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) VIRGIE V. FERGUSON | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
5-12-82 | | | 2b HOUR
10 45 AM | | | |
| 3 SEX
Female | | 4 RACE
BLACK Amer. | | 5 DATE OF BIRTH
MONTH DAY YEAR
02 26 91 | | 6 AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHN L. DEATON MED CTR. | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MD | | 13b COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1105 Bonaparte Ave. | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
unkn | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada Smith | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
224-10-2597 | | 17. INFORMANT
Freddie Ferguson | | ADDRESS
1105 Bonaparte Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
1509
DUE TO, OR AS A CONSEQUENCE OF
(b) Esophageal Cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-27 , 19 82 , to 5-12 , 19 82 , that (I) (we) last saw the deceased alive on 5-12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Christine L. Kirkwood M.D. | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5-12-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Christine L. Kirkwood M.D. | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Co. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 14 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHAM-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 2 6 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR NELLIE V. FEUERHARDT | | | | | | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) Nellie Feuerhardt | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 29 82 | |
| 3. SEX FEMALE | | | | | | | | | | 7b. HOUR 1:00 P.M. | |
| 4. RACE WHITE | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | |
| 5. DATE OF BIRTH MONTH DAY YEAR 02 24 03 | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO. | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH BALTO. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OR BUSINESS (GIVE WORKING LIFE)) HOUSEWIFE | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SBCGH | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MO. | | | | | | | | | | 13b. CITY OR TOWN BALTO. | |
| 13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | 13e. STREET ADDRESS 3566 HORTON AVE. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | | | | | | 16b. SOCIAL SECURITY NO. 212523417 | |
| 17. INFORMANT ADDRESS GEO. J. FEUERHARDT JR. 613 N. BELNORD | | | | | | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE TIME (GIVE BETWEEN ONSET AND DEATH) | |
| IMMEDIATE CAUSE (a) UNKNOWN | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF LUNG CANCER | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | LUNG CA WITH METASTASIS | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. Moser DEGREE | | | | | | | | | | 22c. DATE SIGNED 5/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOSER | | | | | | | | | | 22e. ADDRESS SBCGH | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | | | | | | | 23b. DATE 6/2/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE ANNE ARUNDEL | |
| 24. FUNERAL DIRECTOR John Cook ADDRESS 1211 Chesapeake Ave. | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR JUN 1 1982 | |
| 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] MD. | | | | | | | | | | | |

MEDICAL CERTIFICATION

9 9

1

2534 BP

6 2 2 1 2 2 2

RECEIVED 7 FEBRUARY 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]

--- [illegible] ---

--- [illegible] ---

RE: [illegible]

[illegible]

RE: [illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on page 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 2 7 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>CURTIS</u> <u>FIELDS</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>5</u> <u>10</u> <u>82</u> | | | |
| 3. SEX
<u>M</u> | | | | 4. RACE
<u>BLACK</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>10</u> <u>8</u> <u>16</u> | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<u>65</u> YRS | | | | IF UNDER 1 YEAR MONTHS DAYS
<u>3</u> <u>15</u> | | IF UNDER 24 HRS. HOURS MIN.
<u>AM</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
<u>SOUTH CAROLINA</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>US</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>CITY</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>BALTO CITY</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>PROVIDENT HOSPITAL</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>LONGSHOREMAN</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MARYLAND</u> 13b. COUNTY <u>BALTIMORE</u> | | | | 13c. CITY OR TOWN
<u>BALTIMORE</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>EDWARD</u> <u>FIELDS</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>IDA</u> <u>UNKNOWN</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>NO</u> | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>TARRIAN CORNELIUS</u> <u>5407 LYNVIEW AVENUE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>maximal Hemoptysis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung T.B.</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> 19 <u>82</u> , to <u>5/10</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>M. A. Rashdan</u> DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/10/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>M. A. RASHDAN</u> | | | | 22e. ADDRESS
<u>101 LIONEHEAD CT BALTO MD 21232</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | | 23b. DATE
<u>5-13-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ARBUTUS MEM. PK.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>BALTIMORE MARYLAND</u> | |
| 24. FUNERAL DIRECTOR NAME
<u>E.L. PHILLIPS</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>MAY 12 1982</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Thomas J. [Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMMH-1650M 1/81
(VRA 15, 4)

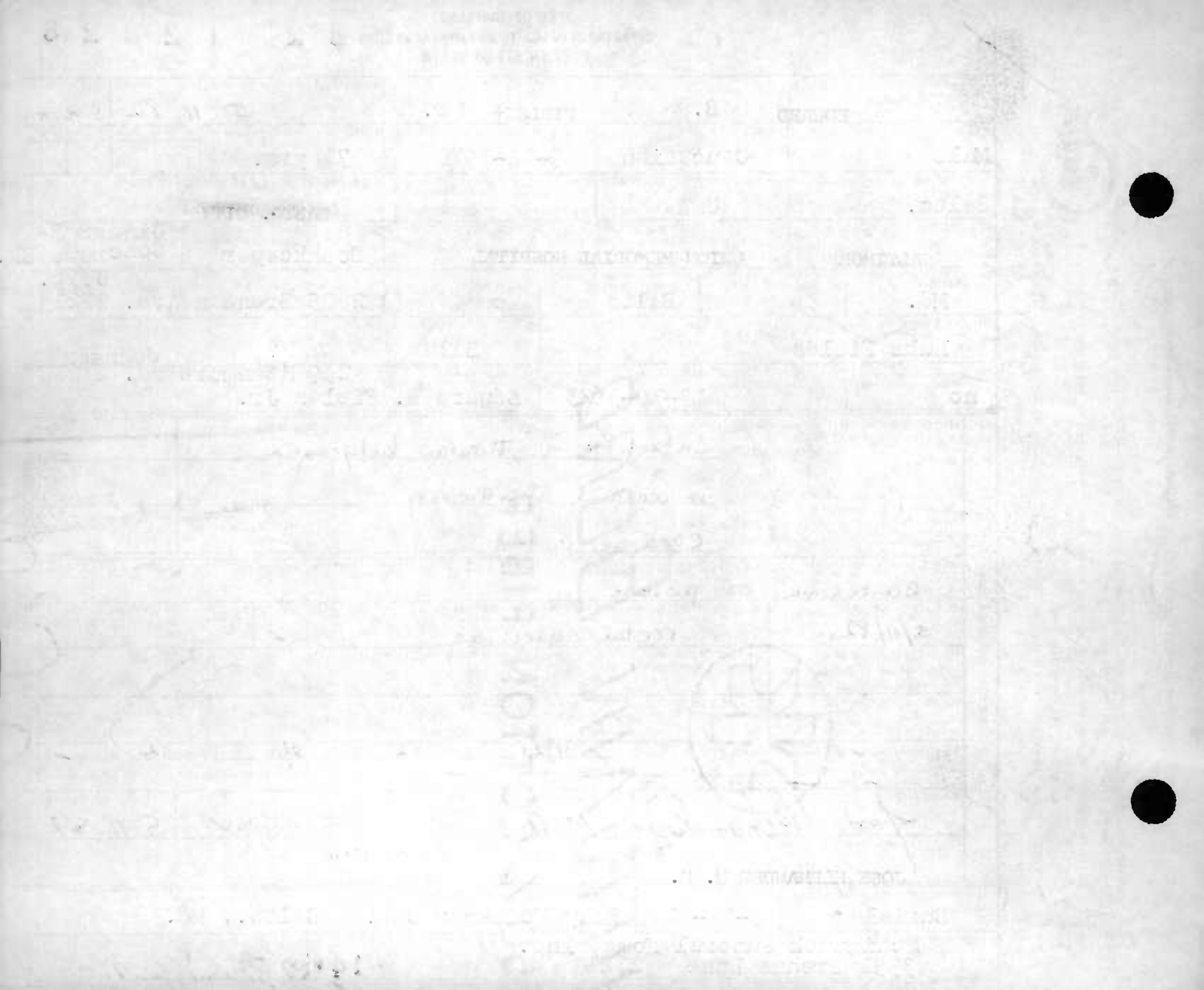
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 2 8

REG. NO.

| | | | | | | |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDWARD B. FIELDS Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 11 82 | | 2b. HOUR
8:40 AM | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
9-24-1910 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 yrs. YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Balto. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. OTHER INDUSTRY OR
Concrete Bk. | |
| 13a. STATE
Md. | | | 13b. COUNTY | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Luke Fields | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-10-3623 | | 17. INFORMANT
259 Stanmore Rd. 21212
Edward B. Fields Jr. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>intactable ventricular tachycardia</u>
DUE TO, OR AS A CONSEQUENCE OF
b) <u>myocardial insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
c) <u>cardiac arrest</u>
1541
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<u>carcinoma of prostate</u> | | | | | | |
| 19a. DATE OF OPERATION
5/11/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
rectal carcinoma | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <u>Mr</u> (this hospital) attended the deceased from <u>4/21</u> , 19 <u>82</u> , to <u>5/11</u> , 19 <u>82</u> , that (I <u>was</u>) last saw the deceased alive on <u>5/11</u> , 19 <u>82</u> , and that in (my <u>own</u>) opinion death occurred on the date and hour and from the causes stated above. (I <u>was</u>) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Jose Hernandez</u> , M.D. | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5-11-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSE HERNANDEZ M. D. | | | 22e. ADDRESS
Union Mem | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-14-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. |
| 24. FUNERAL DIRECTOR'S NAME
Schimunek Funeral Home, Inc.
3331 Brehms Lane 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 14 1982 | | |

MEDICAL CERTIFICATION



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 2 9 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Fields</u> <u>Blanche</u> <u>Fields</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>5</u> <u>17</u> <u>82</u> 2b. HOUR <u>2:55</u> P.M. | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>5</u> <u>26</u> <u>27</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>59</u> yrs. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO, CITY</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>BALTO</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SOUTH BALTO. GEN'L HOSPITAL</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE <u>MD.</u> | | 13b. COUNTY <u>BALTO</u> | | 13c. CITY OR TOWN <u>BALTO</u> | | 13d. STREET ADDRESS <u>601 H. BRIDGEVIEW ROAD</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>James</u> <u>HULL</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Maggie</u> <u>Offler</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | 16b. SOCIAL SECURITY NO. <u>213-00-8306A</u> | | 17. INFORMANT ADDRESS <u>husband Cleveland Fields 601 Bridgeview Rd</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal failure - Sepsis</u>
5902
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>perinephric abscess</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Sepsis</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>5-11-82</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Renal failure - abscess</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-17-82</u> to <u>5-17-1982</u> , that (I) (we) last saw the deceased alive on <u>5-17-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>5/17/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SANTIAGO ZAMUDIO</u> | | | | 22e. ADDRESS <u>3001 S. Halloway St. Baltimore</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5-21-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u> | | 23d. LOCATION CEM. OR TOWN COUNTY STATE <u>Burnie Md</u> | |
| 24. FUNERAL DIRECTOR NAME <u>BROWN-THOMPSON F.H.</u> ADDRESS <u>1913 W. BOLD ST.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 19 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

8 2 2 1 2 0

10 28 6 5

10 28 6 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 3 0 | | | |
|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| EDWIN BENNETT FILBERT | | | | May 11, 1982 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | Jan. 6, 1899 | | 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | USA | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 3525 Newland Road | | Ceramist | | Self-Emp. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS | | | |
| George Filbert | | Selina Bennett | | 3525 Newland Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 212 32 0802 | | Mrs. Portia M. Filbert, Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Emphysema</u>
4920 DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u> | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Acute M.I. 1979</u> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 21g. INJURY OCCURRED | | 21h. PLACE OF INJURY | | 21i. LOCATION | | | |
| | | | | | | | |
| 22a. I certify that (I) <u>(at hospital)</u> attended the deceased from <u>9-8</u> , 19 <u>80</u> , to <u>5-11</u> , 19 <u>82</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>4-30</u> , 19 <u>82</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>William P. Benson, Jr. M.D.</u> | | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5-11-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Dr. William P. Benson, Jr. | | | | 3506 N. Calvert St., Balto., Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5/14/82 | | Druid Ridge | | Pikesville, Md. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| Henry W. Jenkins & Sons Co. 495 4905 York Rd. Balto., Md. 21212 | | | | MAY 13 1982 <u>James J. H. H.</u> | | | |

400 West 10th St., New York, N.Y. 10014
 100 West 10th St., New York, N.Y. 10014

3808 E 1 YAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and on

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 3 1 | |
|--|--|--|--|---|--|---|--|--|--|---------------|--|
| 1- FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) LOUIS J. FISHBEIN | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 5 23 82 | | 2b. HOUR
2:10^{AM} | | | |
| 3. SEX
MALE | | 4. RACE
Cauc | | 5. DATE OF BIRTH
MONTH DAY YEAR 8 18 93 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE
(COUNTRY) RUSSIA
XXXXXX | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. US OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GROCER
XXXXXX | | 12b. KIND OF BUSINESS OR INDUSTRY
FOODS | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY --- 13c. CITY OR TOWN Balto | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS APT. 103 #21215
3812 Fords Lane | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NATHAN XXXXXX FISHBEIN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BLUMA XXXXXX UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO XXXXXX | | 16b. SOCIAL SECURITY NO.
212-16-9171 | | 17. INFORMANT MRS. FLORENCE FISHBEIN ADDRESS 3812 FORDS LANE 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
4360
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (b) postine cerebral vascular
DUE TO, OR AS A CONSEQUENCE OF (c) accident | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Aspiration pneumonia | | | | | | | | | | | |
| 19a. DATE OF OPERATION
--- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10 19 82 to 5/23 19 82 , that (I) (we) last saw the deceased alive on 5/22 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Gerald Gantt MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
5/23/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GERALD GANTT | | | | 22e. ADDRESS
SINAI Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAY 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
SHOMREI HADATH VE TZEMECH SEDEK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO., MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 28 1982 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | | | |

1891

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
1891

1891

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
1891



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 3 2
REG. NO. | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
GIRL FISHER | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 10 82 | | 2b. HOUR
10:30 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 24 82 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
2 17 | | IF UNDER 1 YEAR
IF UNDER 74 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N.A. | | 12b. KIND OF BUSINESS OR INDUSTRY
N.A. | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
md | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
24 S. Berice Ave 21229 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DONNA FISHER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N.A. | | 16b. SOCIAL SECURITY NO.
N.A. | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7690 CARDIO-RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) SEVERE HYALINE MEMBRANE DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 24, 19 82, to May 10, 19 82, that (I) (we) last saw the deceased alive on May 10, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Laurel G. Yag, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/10/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LAUREL G. YAG, M.D. | | 22e. ADDRESS
UNIVERSITY OF MARYLAND HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE
MAY 28 1982 James Van Nuth... | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., Md. | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 2 0 3 3
REG. NO. | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WALTER FRANKLIN FISHER | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 17 82 | | 2b. HOUR
11 P M | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 13 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WYMAN PARK HEALTH SYSTEM | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRUCK DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY
Trucking | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CLARENCE EDWARD FISHER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GRACE BEALE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO. | | 16b. SOCIAL SECURITY NO.
220 05 4672 | |
| 17. INFORMANT
ADDRESS
DAUGHTER 810 W. 35TH ST BALT. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ISCHEMIC HEART DISEASE.
5789
DUE TO, OR AS A CONSEQUENCE OF
(b) GT. A.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
? ENDOCARDITIS. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 11:00pm 5-17-82 to 11:20pm 5-17-82 , that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Jane V. Hoare MD
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JANE V. HOARE MD | | 22e. ADDRESS
WYMAN PARK HEALTH SYSTEM | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | |
| 23b. DATE
5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Balto. Co. MD | | 24. FUNERAL DIRECTOR
NAME
BURGEE | |
| 24b. ADDRESS
3613 FALLS RD. | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 2 1 2 0 3 4 | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Hilda Marie Fishpaw</u> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>05-05-82</u> | | | 2b. HOUR <u>9⁰⁰ A.M.</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>Cauc.</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>6 17 1914</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS) <u>Good Samaritan Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>----</u> | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>Balto.</u> | | 13c. CITY OR TOWN <u>Cockeysville</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <u>811 W. Padonia Road #21030</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Jones --- Combs</u> | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST <u>Hattie Stewart</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No.</u> | | 16b. SOCIAL SECURITY NO. <u>214-14-5304</u> | | 17. INFORMANT ADDRESS <u>Shrewsbury, Pa.</u> | | | | | |
| | | | | George F. Fishpaw, Jr., 32 Virginia Ave. | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cordis - pulmonary embolism</u>
<u>1991</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Melancholia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION <u>5/4/82</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Liver mass.</u> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/5 1982</u> to <u>5/5 1982</u> , that (I) (we) lost saw the deceased alive on <u>5/5 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>M.O. Annun</u> | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>5/5/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MUHAMMAD ANNUN</u> | | | | 22e. ADDRESS <u>Good Sam Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/8/1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY <u>Upperco Balto. Maryland</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Lemmon-Mitchell-Wiedefeld</u> | | | | ADDRESS <u>10 W. Padonia Rd.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>02 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>James Van Natten</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 1 2 0 3 5
REG. NO. | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST
Elsie Fletcher | | 2a. DATE OF DEATH MONTH DAY YEAR
5 28 82 | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
09/29/04 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Md | | 13b. COUNTY
— | | 13c. CITY OR TOWN
Baltimore City | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frank McDonald | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Smith | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Charles Fletcher 2419 Seaman Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 HRS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/28/82 , 19____, to 5/28/82 , 19____, that (I) (we) last saw the deceased alive on 5/28/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Neal M. Friedlander, MD | | DEGREE
MD | | 22c. DATE SIGNED
5/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neal M. Friedlander | | 22e. ADDRESS
Mercy Hospital 301 St. Paul St, Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. Nat. Cem. | |
| 23d. LOCATION CITY OR TOWN
Balto. City | | COUNTY
Md. | | STATE | |
| 24. FUNERAL DIRECTOR NAME
Chas. A. Rice FSPA 1300 Eutaw Pl. | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

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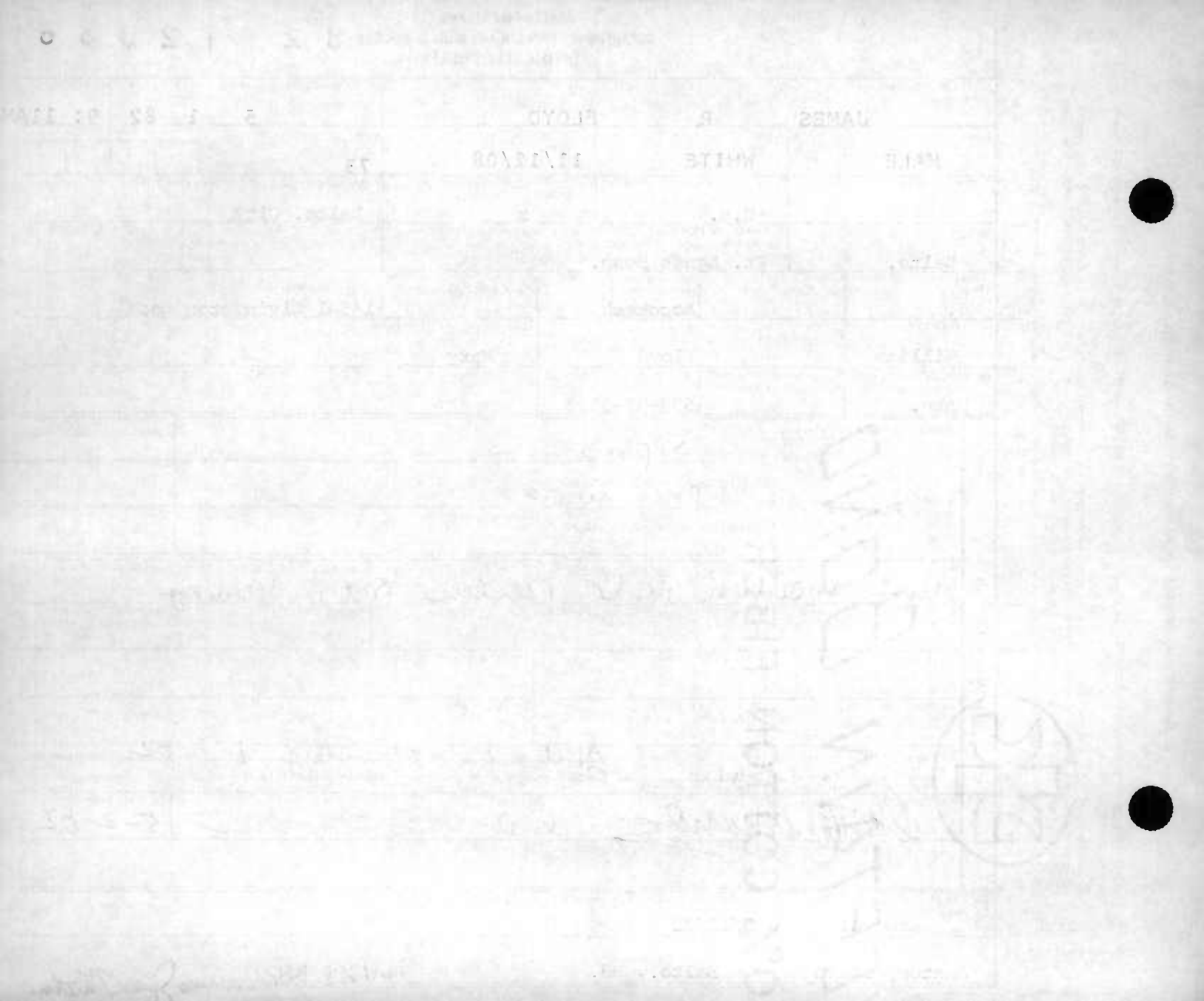
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 3 6 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| I. DECEASED NAME | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| JAMES R FLOYD | | | | 5 1 82 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | 11/12/08 | | 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| | | U.S. | | | | Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | | St. Agnes Hosp. | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | |
| 13a. STATE COUNTY | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| Md. P.G. Accokeek | | | | 13e. STREET ADDRESS | | | |
| | | | | 14501 Livingston Road | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| William Floyd | | Mary | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Unkn. | | 579-89-9528 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Sepsis | | | | | | | |
| 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia. | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| Anti Abdomen Renal Failure, Gastric Bleeding. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 27, 1982, to May 1, 1982, that (I) (we) last saw the deceased alive on May 1, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 5-2-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Removal | | 5/12/82 | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Anatomy Board Balto., Md. | | | | MAY 21 1982 | | James J. Norton | |



JAMES R.

FLOYD

WHITE

12/14/08

NOTED

COTTON

MAY 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

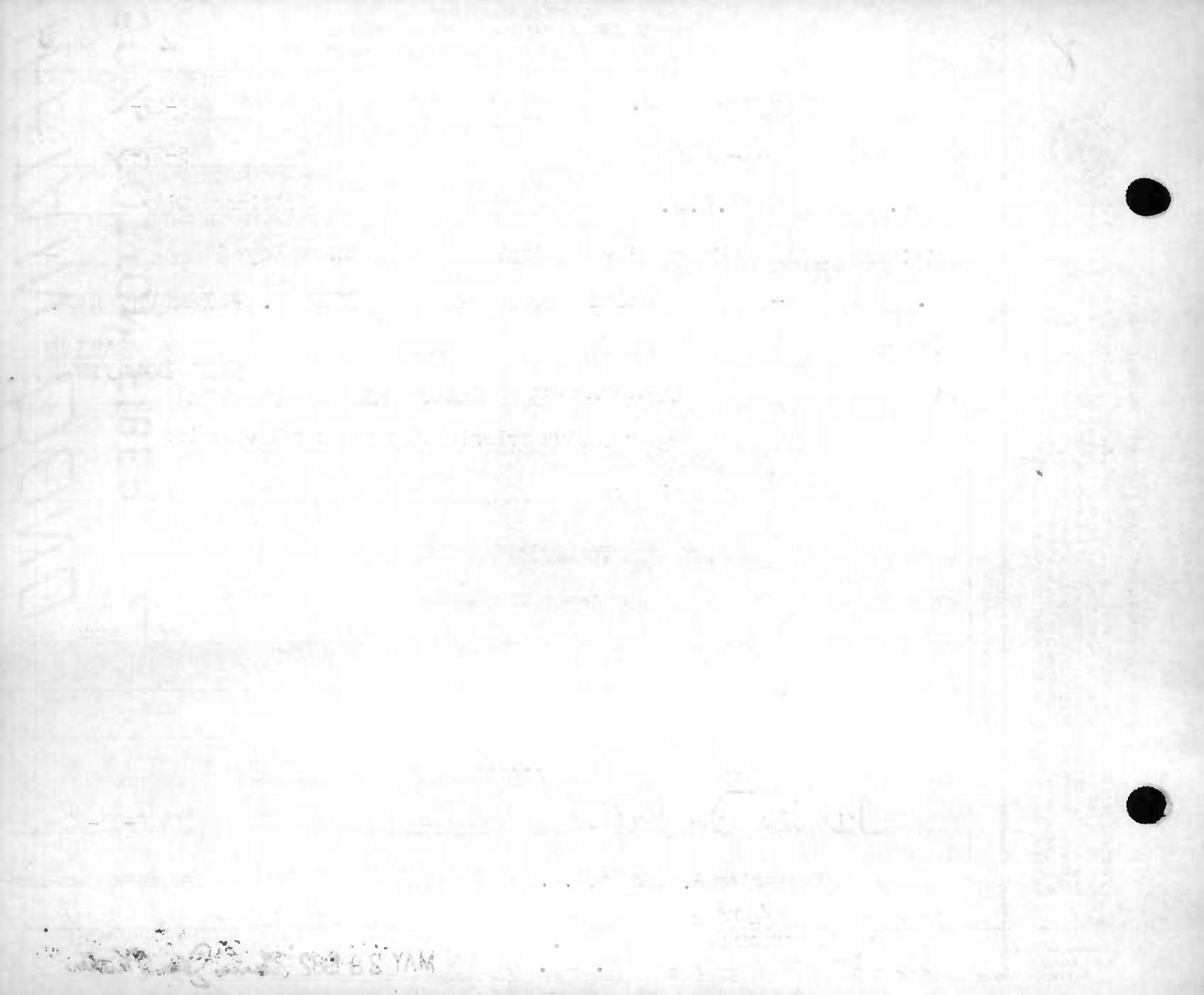
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 3 7 | | | |
|--|--|--|--|--|--|--|--|---|--|-----------------|-----|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Ralph S. Fogle | | | | | | | | 5 | | 12 | 82 | 1055A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | 6 9 17 | | 64 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Md. | | U. S. A. | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Balto. | | Bon Secours Hospital | | Retired-Mass Transit | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Md. | | Balto. | | | | | | 5555 Link Ave. | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | |
| Daniel Fogle | | Blanche E. Eyler | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Yes | | 703-07-4104 | | Mrs. Lorraine E. Fogle | | 5555 Link Ave. #21227 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Liver Metastasis | | | | | | | | | | | | 2 months | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Undifferentiated Lung Cancer | | | | | | | | | | | | C month | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12, 19 81, to 5/12, 19 82, that (I) (we) lost saw the deceased alive on 5/11, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | |
| DKonits | | | | | | 5/12/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| PKonits | | Lutheran Hospital | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 5-15-82 | | Laurel Mem. Park Cem. | | Balto.-Laurel, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| G. T. Schwab | | 5151 Balto. Nat'l Pike #21229 | | MAY 17 1982 | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12038 | |
|--|--|------------------|--|---|--------------------------------|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
SALVATORE J. FONTI | | | | | | | | | | XX MONTH DAY YEAR
5-27-82 | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH (MONTH DAY YEAR)
4-2-1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
5-27-82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
Md. | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2714 E. FAIRMOUNT AVE. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
VINCENT FONTI | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY DAMICO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
218-09-0593 | | 17. INFORMANT ADDRESS
GRACE MATTESE (SISTER) 3611 BONVIEW AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) XXXXXXXXXXXXXXXXXXXX
Hypertensive arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margareta A. Koroll | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
5-27-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margareta A. Koroll, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
5/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION CITY OR TOWN
Baltimore | | 23e. STATE
Md. | |
| 24. FUNERAL HOME NAME
Schrimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 28 1982 | | 25b. REGISTRAR'S SIGNATURE
John J. Kistner | | | |



FIBER

DEMAND

NOV 25 1965

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR "GOURT FILES" TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12039 | |
|--|---------|---|-------------------|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| ROBERT | | A. | | FOREWOOD | | (FORWOOD) | | 5 22 19 82 | | 11:37 a.m. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| MALE | CAUCAS. | 12 16 57 | 24 YRS. | MONTHS | | DAYS | | 5 22 19 82 | | 11:37 a.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | USA | | YES | | WIDOWED | | Baltimore City | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | University Hospital | | DISABLED | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | BALTIMORE | | ROSEDALE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 8063 PHILADELPHIA RD. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| JAMES | | NANCY | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 214727621 | | JACQUELYN FORWOOD | | 8063 PHILA. RD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head (unspecified weapon)
9554
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | 12:02 M. 5-21-1982 | | self-inflicted. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| | | home | | 8063 Philadelphia Rd. | | Balto. | | Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| Ann M. Dixon, M.D. | | Assistant | | 5-23-82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | STATE | |
| CREMATION | | 5/26/82 | | WESTVIEW CEMETERY | | BALTO. | | BALTO. | | MD. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| J. J. Con | | 1211 Chesapeake Ave. | | MAY 24 1982 | | Theresa. Van Natta | | | | | |

1994-1995

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 4 0

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES FORD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05/08/82 | | 2b. HOUR
7:50 PM |
| 1. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 6 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. STREET ADDRESS
1412 N. Milton Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Ford | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-05-2762 | 17. INFORMANT ADDRESS
Mary Ford 1412 N. Milton Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hypoxia
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia and pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(c) coma | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/24 , 19 82 , to 5/8 , 19 82 , that (I) (we) lost
saw the deceased alive on 5/8 , 19 82 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If I (we) did not view the body after death.) | | | | | |
| 22b. SIGNATURE
R. Garver | | DEGREE
MD | | 22c. DATE SIGNED
5/8/82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
R. GARVER | | 22e. ADDRESS
JOHNS HOPKINS HOSP
DEPT. OF MEDICINE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/14/82 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H 1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1982 | | 25b. REGISTRAR'S SIGNATURE
Dan Nathan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 4 1 | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | |
| Mabel Louise FORTNER | | | | 5-15-82 3:35 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | Cauc. | | 7 MONTH 15 DAY 1924 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS, LAST BIRTHDAY) | |
| Virginia | | U. S. A. | | 57 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | BALTIMORE CITY MD | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Homemaker | | | | ----- | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS | | | | | |
| Maryland --- Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 3545 Shannon Drive | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | |
| Floyd Jefferson Combs | | | Betty Maude Smith | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 212-24-8477 | | Baltimore, Md. 21213 Sidney J. Fortner, 3545 Shannon Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4100 Cardiac arrest | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction | | | | | 30 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery atherosclerotic disease | | | | | 48 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-13-82 to 5-15-82, that (I) (we) last saw the deceased alive on 5-15-82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | |
| Francis J. Townsend III MD | | | | 5-15-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| FRANCIS J. TOWNSEND III | | | | 201 E. University Parkway | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/18/1982 | | Mays Chapel Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE | | | |
| Timonium Balto. Maryland | | MAY 20 1982 Francis J. Townsend | | | |
| 24. FUNERAL DIRECTOR'S NAME ADDRESS | | | | | |
| Lemmon-Mitchell-Wiedefeld Inc. 10 W. Padonia Rd. | | | | | |

BALTIMORE

UNION TENDERS REPORTED

YTD: 200508

INDEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|--|--|--|--|--|
| Item #1 FOR 5/28/82 rc | | Home STATE OF MARYLAND | | 8 2 1 2 0 4 2 | |
| 1. STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | REG. NO. | |
| VIRGINIA. LOUISE FOSBURG | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 8. CITIZEN OF WHAT COUNTRY? USA | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEWING TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY SCHOOL | | 13a. STATE MD. | |
| 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY BUCHANAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDIE HAWKINS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 220-05-0534 | | 17. INFORMANT ADDRESS EDWARD L. FOSBURG 708 HOLLEN RD. 21212 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAROTID ARTERY - BRADYCARDIA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes | | 7101 | |
| DUE TO, OR AS A CONSEQUENCE OF (b) SLEADDERHA | | DUE TO, OR AS A CONSEQUENCE OF (c) | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from May 17 1982, 19 82, to May 18 19 82, that (I) (we) lost saw the deceased alive on May 17 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | 22b. SIGNATURE DEGREE | |
| 22c. DATE SIGNED 5/17/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEANNE McCAULEY MD | | 22e. ADDRESS GOOD SAMARITAN HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAY 21, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | 24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212 | | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982 | |

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

BALTIMORE CITY

CHURCH STREET

100 WEST 100

300-02-0200 STANLEY I. STANLEY 100 WEST 100

STANLEY I. STANLEY

STANLEY I. STANLEY 100 WEST 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a coroner's inquest held.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 4 3 |
|--|--|---|--|---|---|--|--|---|--|---------------|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Sophie Fowble | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/24/82 | | | 2b. HOUR
1:04 P.M. | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 8 91 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Pleasant Manor Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Balt. 13c. CITY OR TOWN City Baltimore | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3703 Rolling Road | | | |
| 4. FATHER'S NAME
FIRST MIDDLE LAST
Paul Klatt | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Krieling | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
212077656 | | 17. INFORMANT ADDRESS
Mrs. Dorothy Glaser 7418 Rockridge Rd 21208 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis of heart vessels
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis of heart vessels
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
arteriosclerosis of heart vessels | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 22 , 19 81 , to May 24 , 19 82 , (that (I) (we) lost saw the deceased alive on May 24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Therese Levin M.D. | | | | | 22c. DATE SIGNED
5/24/82 | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
MANUEL LEVIN M.D. | | | | | 22f. ADDRESS
6101 PK HOTS AVE BALTO. MD 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | 23e. DATE REC'D. BY REGISTRAR
MAY 26 1982 | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
A. Alan Seitz Funeral Home 3818 Roland Ave. | | | | | 25. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 2 0 4 4 | |
|--|--|---|--|--|--|--|--|---|--|------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ARNOLD M. Fowler | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 26 82 | | 2b. HOUR
145 P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
April 18, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 11. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Office Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY
Motel | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5702 Beechdale Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Henry Fowler, Br. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Hazel Kirkwood | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
213-14-9713A | | 17. INFORMANT
Stevensville, Md. 21666
Margaret F. Papa, 121 North Lake Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5326 Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) Intact abdominal Abscess
DUE TO, OR AS A CONSEQUENCE OF (c) perforation of duodenum | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Two months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
5-15-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Massive GI And Flank wound Bleeding | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-25-82, 1982, to 5-26-82, 1982, that (I) (we) lost the deceased alive on 5-26-82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Bethany Pharoan | | | | DEGREE | | | | 22c. DATE SIGNED
5-26-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE COMPLETE)
PHAROAN | | | | 22e. ADDRESS
Good Samaritan Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 29, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Woodlawn, Balto., Md. | | | | | |
| 24. FUNERAL HOME
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 28 1982 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Frances Jean Neithaus | | | | | | | | | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 4 5

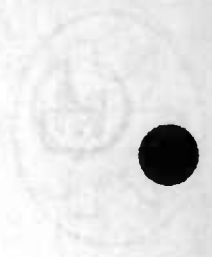
REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary Fowler | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 5 1982 | | 2b. HOUR
M
 |
| 3. SEX
female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YR.
3 6 84 | 6. AGE (IN YEARS LAST BIRTHDAY)
98 | IF UNDER 1 YEAR
MONTHS DAYS
 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1629 E. Preston St. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1629 E. Preston St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Brown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Barnes | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
N/A | 17. INFORMANT ADDRESS
Jean Gentry 917 N. Kenwood Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
4280 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dementia
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 m
5 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Congestive Heart Failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 5/2 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
M. G. Midei | | DEGREE
MD | | 22c. DATE SIGNED
5/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Midei | | 22e. ADDRESS
600 N. Wolfe, Balt, MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/11/82 | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 E. North Ave | | | 25a. DATE REC'D. BY REGISTRAR
MAY 7 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Frances Jan Tharion | | |

U.S. 1 2 2

U.S. 1 2 2

U.S. 1 2 2



[Faint, illegible text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) David FOWLKES | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 2, 1982 | | | | | |
| 3. SEX
Male | | | | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 27 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1637 Gwynns Falls Pkwy. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Fowlkes | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clementine Carrington | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
217-01-0387 | | 17. INFORMANT
ADDRESS
Louise Fowlkes 1637 Gwynns Falls Pkwy. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aortic Arch Aneurysm
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 5, 1982 to May 2, 1982 , that <input checked="" type="checkbox"/> we lost saw the deceased alive on May 2, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Robert Ammlung | | | | DEGREE
no | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/2/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Ammlung M.D. | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 3 1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Natten | | | | |

0 2 0 1 0

May 22 1952

FOUR

1952

Baltimore City

Baltimore General Hospital

Baltimore

Admitted from Intensive

Postoperative

May 2

April 2

May 2

May 2

Admitted from Intensive

Postoperative

May 2

2062010MAY 13 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 4 7

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Rosa B. Foy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 15, 1982 | | 2b. HOUR
M | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 24 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2009 N. Monroe St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Bell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucille Lipsey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Annie Loving 2009 N. Monroe St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Sepsis
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) UTI, Renal failure
DUE TO, OR AS A CONSEQUENCE OF
(c) CHE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/12 19 82 , to 5/15 19 82 , that (I) (we) last saw the deceased alive on 5/14 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
[Signature] | | | | 22e. ADDRESS
Mercy Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | 23b. DATE
5/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Church Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Savannah GA | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE RECEIVED BY REGISTRY
MAY 17 1982 | | | |
| | | | | 25b. SIGNATURE
[Signature] | | | | | |

SECRET

SECRET

Items 13a-e per phone 6/14/82 ddd STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 0 4 8
 CERTIFICATE OF DEATH REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
NICOLE R. FREBURGER | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 15, 1982 | | 2b. HOUR
M
M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
5 12 82 | | 6. AGE (IN YEARS LAST BIRTHDAY)
3 days XX | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
--- | | 12b. KIND OF BUSINESS OR INDUSTRY
--- |
| 13a. STATE
Md. -- | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
-- | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Timothy L. Freburger | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Debra | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
-- | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT ADDRESS
Robert Freburger 4412 Mountview Road 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
5860 IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Renal Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
40 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Oligohydramnios | | | | | |
| 19a. DATE OF OPERATION
May 12 1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
19 | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>May 12</u> 19 <u>82</u> , to <u>May 15</u> 19 <u>82</u> that (we) lost saw the deceased alive on <u>May 15</u> 19 <u>82</u> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (s/he) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Pamela J. Stone</i> | | DEGREE
MD | | 22c. DATE SIGNED
5/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Pamela J. Stone | | 22e. ADDRESS
Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
5/19/82 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | 24b. ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Thomas J. [Signature]</i> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the decedent be examined within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the decedent has been examined, this certificate should be detached for use as the burial-transit permit. Then please repackage carbon pages 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1937 JUN 23 A

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 4 9

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE OF DEATH | | 3. HOUR | |
| Lee, Freeland, Lee | | 6-74-14-99 | | 2 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| M | | white | | 6-14-97 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Virginia | | U S A | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | BON SECOURS Hosp. | | Farmer | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | |
| James William Lee | | Virginia Drish | | 3012 Highman Avenue | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 228 - 38 - 2851 | | William Lee, Baltimore, Md, 21230 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 18b. DUE TO, OR AS A CONSEQUENCE OF (b) | | 18c. DUE TO, OR AS A CONSEQUENCE OF (c) | |
| 4960 C. V. A. | | C. A. F. | | C. O. P. D. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | b | | c | |
| A207mia, Dehydration, Poor P.O. INTAKE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | |
| | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-9-1982 to 5-14-1982, that (I) (we) lost saw the deceased alive on 5-13-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | 22b. SIGNATURE A. P. Miller M.D. DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| AJAIR S. SIDHU | | 5216 Younger Rd. Columbia, Md 21044 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | May 18, 1982 | | Green Hill Cemetery Berryville, Clarke Virginia | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |
| James Van Wagoner | | | | MAY 28 1982 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 0 | 5 | 0 |
|--|--|---|--|---|--|---|--|--|--|--|---|-------------------------------|---|---|---|---|
| CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Anna NMI FREEMAN | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 24 82
2b. HOUR
4 ⁰⁰ PM | | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 2 80 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 74 HRS
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK, BUSINESS OR WORKING LIFE)
housewife unknown | | 12b. KIND OF BUSINESS OR INDUSTRY
unknown | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1122 N. Carey St. | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Mackell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLA FOWLER | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
218-14-3406 | | 17. INFORMANT
Admitting papers | | | | ADDRESS | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio pulmonary failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial ischemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pulmonary edema</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
72 hours | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-20-82 to 5-24-82, that (I) (we) last saw the deceased alive on 5-24-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
David L. Wilson MD | | | | DEGREE | | | | 22c. DATE SIGNED
5-24-82 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David L. Wilson MD | | | | 22e. ADDRESS
Univ. of Md. Hospital
Fayette and Greene St. 21201 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
May 29, 82 | | 23c. NAME OF CEMETERY OR CREMATORY
Patuxent Chr. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Huntingtown Calvert Md. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Spencer E. Sewell Box 31, Prince Frederick, Md | | | | 25a. RECEIVED BY REGISTAR
JUN 1 1982 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 5 1
REG. NO. | |
|---|--|--|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GRACE L. FREEMAN | | | | | 2a. DATE OF DEATH
MONTH 5 DAY 14 YEAR 82 | | | 2b. HOUR
9:30 AM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 10 DAY 6 YEAR 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DANVILLE, VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | |
| 13a. STATE
MD | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
609 N. Pitcher St. | | | |
| 14. FATHER'S NAME
FIRST Henry MIDDLE Lewis LAST Lewis | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Lottie MIDDLE Clark LAST Clark | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
ADDRESS
Frances Graves 609 N. Pitcher St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
1579
DUE TO, OR AS A CONSEQUENCE OF
(b) CANCER OF THE PANCREAS
DUE TO, OR AS A CONSEQUENCE OF
(c) ---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
--- P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 11, 1982 , to MAY 14, 1982 , that (I) (we) lost the deceased alive on MAY 14, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J. M. Jumanoy, M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
5/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. M. JUMANOY, M.D. | | | | | 22e. ADDRESS
PROVIDENT HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
5/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR Hill | | | 23d. LOCATION
CITY OR TOWN BALTO. COUNTY MARYLAND STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME James A. Morton & Sons ADDRESS 1701 LAURENS ST. | | | | | 25a. DATE REC'D
MAY 14 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Smith | | | | |

120512031



TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]

4. [illegible]
5. [illegible]
6. [illegible]

7. [illegible]
8. [illegible]
9. [illegible]

10. [illegible]
11. [illegible]
12. [illegible]

13. [illegible]
14. [illegible]
15. [illegible]

16. [illegible]
17. [illegible]
18. [illegible]

19. [illegible]
20. [illegible]
21. [illegible]

22. [illegible]
23. [illegible]
24. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 5 2

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
AARON | | | FIRST MIDDLE LAST
FRIEDMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 17 82 | | | 2b. HOUR
8:10A M | | | |
| 3. SEX
M | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 1, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
67 | | | IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | IF UNDER 24 HRS
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN A HEALTH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(GIVE WORK FOR MOST OF WORKING LIFE)
OWNER | | | 12b. KIND OF BUSINESS OR INDUSTRY
GROCER | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | | | 13b. COUNTY
BALTIMORE | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LOUIS FRIEDMAN | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CELIA CAPLAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
216-01-0653 | | 17. INFORMANT ADDRESS
(21215)
MRS. FREEDA FRIEDMAN 3634 FORDS LANE APT. E | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CANCER OF STOMACH
1519
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 MONTHS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (11a)
HEPATIC METASTASES, PLEURAL EFFUSION. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr. 14 , 19 82 , to May 17 , 19 82 , that (I) (we) lost
saw the deceased alive on May 16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Elizabeth G. Lin | | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5-17-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELIZABETH G. LIN | | | | | | 22e. ADDRESS
SINAI HOSPITAL OF BALTIMORE | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL/REMOVAL | | | 23b. DATE
5/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
HAR MENUCHA CEM | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
JERUSALEM. ISRAEL | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS
6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 18 1982 | | 25b. REGISTRAR'S SIGNATURE
Francis J. [Signature] | | | | |

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 0 | 5 | 3 |
|--|--|--|--|--|------------------------------------|--|---|---|--|---|---|-----------------|--|-----------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| I. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR | | | | | | |
| WILLIAM G. FROMM | | | | | | | | | | May 2 82 3PM M | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | | White | | | 8 MONTH DAY YEAR | | | 64 YRS | | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Md. | | | U.S.A. | | | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Balto. | | | St. Agnes Hospital | | | | | | | Chauffeur | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 4719 Dartford Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Frederick Fromm | | | | | | | | | | Anna Cunningham | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| No. | | | | | | | | | | 213-16-4532 | | | 4719 Dartford Ave., #21229 Mrs. Jean Milne Fromm | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 1890 Adenocarcinoma of right kidney with metastasis. | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-20, 19 82, to 5-2, 19 82, that (I) (we) lost saw the deceased alive on 5-2, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | | | | | | | 22c. DATE SIGNED | | | | | | |
| Laurence Zidman MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | 5-2-82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | |
| | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | |
| Burial | | | 5-6-82 | | Mt. Olivet Cem. | | | Balto. MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| G. Truman Schwab 3512 Frederick Ave., #21229 | | | | | | | | | | MAY 10 1982 | | | | | | |

250

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|-----------------------------------|--|--|--|--------------------------|--|--------------------------------------|--|------|--|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Elijah A. Gadsden | | | | | | | | 5 27 1982 | | | | | | | | 11:20 a.m. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | Black | 8 29 59 | | 22 YRS. | | MONTHS | | DAYS | | 5 27 1982 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| S.C. | | USA | | | | | | | | | | Baltimore City, | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | University Hospital | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| PA | | Harrisburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4403 C Oneida Drive | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| — | | Mililda B. Gadsden | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | N/A | | Evelyn G. Williams | | 433 Peffer St. Harrisburg, PA | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Multiple injuries | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 8820 | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 8:49xx 5 27 1982 | | Subject fell from building | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| building | | 414 Light St. | | Baltimore | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | |
| Thomas D. Smith, M.D. | | III Penn St. Balto., MD. | | | | 5/28/82 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Burial | | 6/4/82 | | Church Cemetery | | Charleston | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Wm. C. March F/H | | 1101 E. North Ave. | | | | JUN 3 1982 | | James J. Smith | | | | | | | | | |

2009 COLLOX-613EB
NEW BOND

2009 COLLOX-613EB

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 5 5

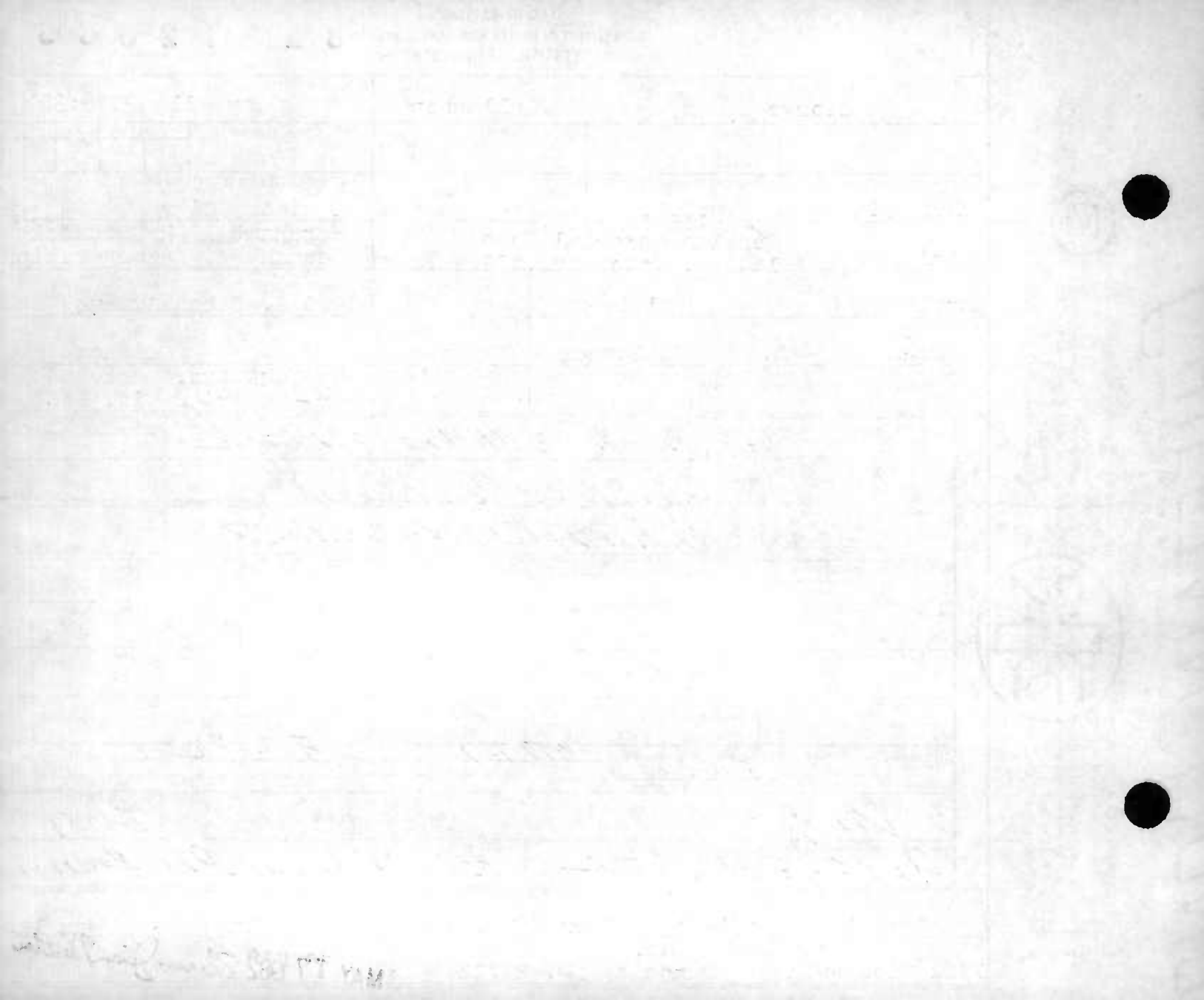
FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
George J. Gallagher | | | 2a DATE OF DEATH
MONTH DAY YEAR
May 11 82 | | | 2b HOUR P
6:30 ^P M | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
10 6 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS
HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Jenkins Memorial Home
1000 S. Caton Ave. 21229 | | | | 12a OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Merchant Seaman | | 12b KIND OF BUSINESS OR INDUSTRY
Arundel Corporation | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b COUNTY
Baltimore | | 13c INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS
1000 S. Caton Avenue | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John A. Gallagher | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sara Neidham | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b SOCIAL SECURITY NO
213-16-3148 | | 17 INFORMANT ADDRESS
1900 New York Ave. Apt. 304
Mary Gallagher - Superior, Wis. 54880 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line; do not list more than 3 causes)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (1a)
2500 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) }
(c) }
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1a)
19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED
20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/>
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f LOCATION
STREET CITY OR TOWN COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from 10-7-82 to 11-4-82, that (I) (we) last saw the deceased alive on 5-11-82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.
22b SIGNATURE
DEGREE
22c DATE SIGNED
5-17-82
22d PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE ANPOV
22e ADDRESS
3350 Wilkerson Dr. Beltsville | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
5/14/1982 | | 23c NAME OF CEMETERY OR CREMATORY
Sacred Ht. Of Jesus | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | |
| 24 FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc.
7922 Wise Avenue Dundalk, MD. 21222 | | | | 25a DATE REC'D. BY REGISTRAR
MAY 17 1982 | | 25b REGISTRAR'S SIGNATURE
Francis J. [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. IT MUST BE YOUR RESPONSIBILITY TO RETURN PAGES 1 AND 2 TO THE DIVISION OF VITAL RECORDS, 201 WESTERN AVENUE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH-17
(VR A15 ME (5))
15M2/80

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250

OFFICE OF THE
DIRECTOR



UNITED STATES OF AMERICA

MAILED MAY 17 1966
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250

MAIL ROOM

III

MAY 17 1966
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 88 12 06 527 | |
|---|--|--|--|---|---------------------------|---|--------------------------------------|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| FIRST MIDDLE LAST
James - Gardner | | | | | MONTH DAY YEAR
5 11 82 | | | | | 11:55 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | |
| m | | N | | MONTH DAY YEAR
7 25 12 | | | 69 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| SOUTH CAROLINA | | US of A | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | St. Agnes Hospital | | | | RETIRED | | | GAS & ELECTRIC CO. | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 409 GWYNN AVENUE | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST
WILLIE GARDNER | | | | | FIRST MIDDLE LAST
? ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | | | | 238 16 3359A | | MRS. OLA M. GARDNER 409 GWYNN AVENUE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> | | | | | | | | | | less than 1 hour | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>August 5, 1980</u> to <u>March 20, 1982</u> that <u>he</u> (we) lost <u>saw</u> the deceased alive on <u>March 20, 1982</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <u>T. P. Reddy</u> | | | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 5/11/1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| DR. T. P. REDDY | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | | | |
| BURIAL | | 5/17/82 | | CEDAR HILL CEMETERY | | BALTIMORE (AA Co.) | | MD. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR SIGNATURE | | | |
| LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE | | | | | | MAY 14 1982 | | <u>James Gardner</u> | | | |

THOMAS T. GAYNOR 4517 PARK HEIGHTS AVENUE

BORIS L 5/17/85 GILDA RILEY CEMETERY BALTIMORE (11 Co.) MD.

938 10 3352A

MRS. GUY M. GARDNER 409 GUYMAN AVENUE

WHITE

GARDNER

?

HARVARD

BALTIMORE

X

409 GUYMAN AVENUE

BALTIMORE

BALTIMORE

CITY OF BALTIMORE

SOUTH CAROLINA

US of A

X

BALTIMORE CITY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARGARET M. GARDNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 5, 1982 | | | 2b. HOUR
12: noon | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 27, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUTTON PLACE 1111 PARK AVE. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
GOVERNMENT | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1111 PARK AVE. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE L. GARDNER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET M. SHOTT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-03-0453 | | 17. INFORMANT ADDRESS
MISS. IRENE C. GARDNER 1111 PARK AVE. | | | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac pulmonary Arrest
1940
DUE TO, OR AS A CONSEQUENCE OF
(b) Neuroblastoma
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from APRIL 19 81 to APRIL 19 82 , that (I) (we) last saw the deceased alive on APRIL 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Myo Thuy | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MYO THUY | | | | 22e. ADDRESS
901 FRANKLIN ST. DR
BALTO, MD 21237 | | | |

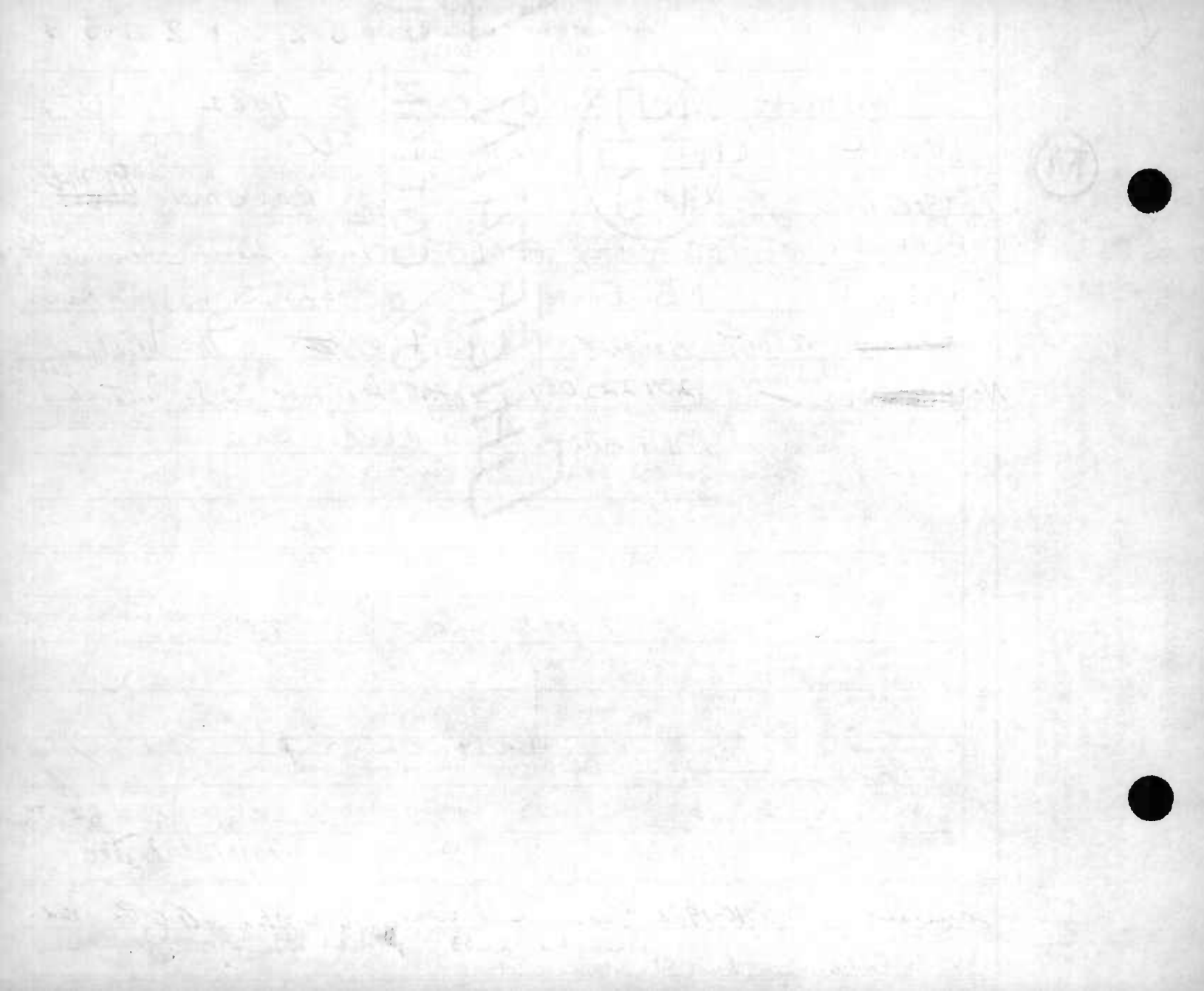
| | | | | | | | |
|--|--|---------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MAY 8. 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212 | | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAY 13 1982 Frances Jean Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Wilbert L. GARDNER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-7-82 | | 2b. HOUR
12 ²⁰ AM | | |
| 3. SEX
male | | 4. RACE
Cau | | 5. DATE OF BIRTH MONTH DAY YEAR
8-4-21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | 7. UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore | | 10. BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Lumber Co. | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
32. S. Fulton Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown Albert Gardner | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Bertie (S.) McMillin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No Unknown | | 16b. SOCIAL SECURITY NO.
239 225 087 | | 17. INFORMANT ADDRESS
Betty Gardner 32 S. Fulton Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of liver
1991
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | |
| 19a. DATE OF OPERATION
4-28-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Open liver for liver ca. | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (if (this hospital) attended the deceased from above, (my) (did) (did not) view the body after death.
4-19-1982 to 5-7-1982, that (he) (we) lost saw the deceased alive on 5-6-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE
R.D. ARORA | | | | | DEGREE
MD. | | | 22c. DATE SIGNED
5-7-82 12 ³⁰ AM | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS
St. Agnes Hospital, Balto. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
burial | | 23b. DATE
5-10-1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Hill Co. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ches. Ph. 21223 Md. | | | |
| 24. FUNERAL DIRECTOR NAME
John J. Cowan & Son Inc 901 Hollins St. | | | | | 25a. D. BY HEALTH OFFICER 25b. REASON FOR SIGNATURE | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

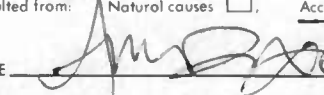

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 8 2 1 2 0 6 0 | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| FIRST MIDDLE LAST
Beatrice Fooks Gurnes | | | | 5 | | 29 | | 82 | | 11:00 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | | 9. IF UNDER 24 HRS. | |
| Female | | Black | | 9 MONTH 4 DAY 23 YEAR | | 58 | | YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| VA | | USA | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | | 3814 Greenspring Avenue | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MD | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3814 Greenspring Ave. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST
William A. Fooks | | | | FIRST MIDDLE
Sarah E. Charity | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | 219-18-4464 | | Michael Gurnes 3814 Greenspring Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma / lung</u>
1609
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>82</u> , to <u>May 27</u> , 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>May 24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE
Davis M Hahn MD
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Davis M Hahn | | | | 22c. DATE SIGNED
5/27/82 | | 22e. ADDRESS
5801 Loch Raven Blvd 21239 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 6/3/82 | | Druid Ridge Cem. | | | | Baltimore Co. MD | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | JUN 3 1982 | | | | James J. Hahn | | | | | |

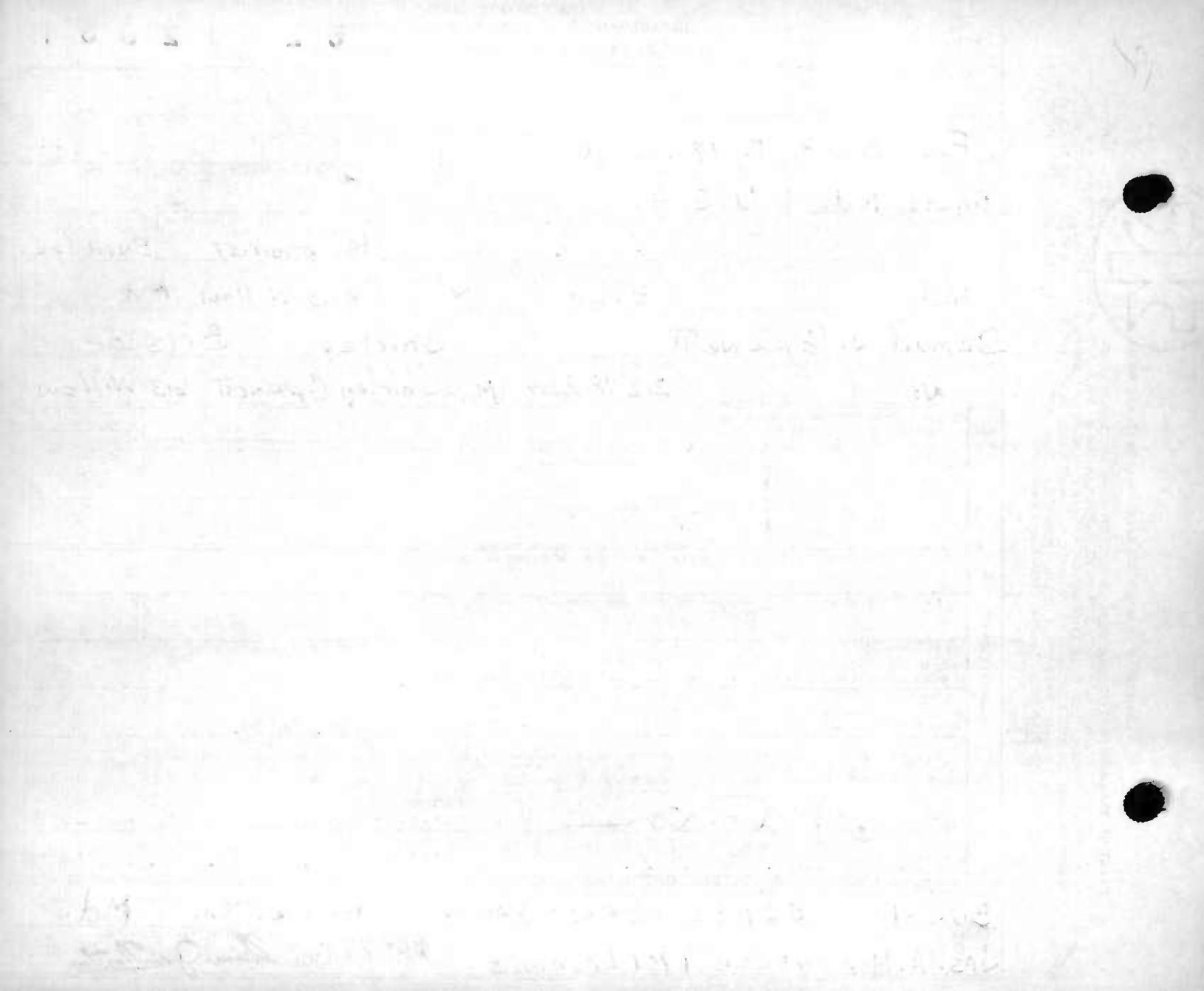


[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12061 | |
|--|----------------------|--|---|---|--------------------------------|--|--|---|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) INGER GARNETT | | | | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5 24 1982 | | 21. HOUR M | | | |
| 3. SEX Fe | 4. RACE Black | 5. DATE OF BIRTH
MONTH DAY YEAR 2 18 62 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 20 | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 22. DATE PRONOUNCED DEAD
MONTH DAY YEAR 5 24 1982 | | 23. HOUR 5:53
a M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2551 Edmondson Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Receptionist | | 12b. KIND OF BUSINESS OR INDUSTRY
Envelope. | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STREET ADDRESS
613 Willow Ave. | | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel J. Garnett | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Shirley Briscoe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
212 78-2319 | | 17. INFORMANT ADDRESS
Mrs. Shirley Garnett 613 Willow | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke & soot inhalation
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5:35xx 5-24- 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
House fire. | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
house | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2551 Edmondson Ave., Balto. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 5-24-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY CREST LAWN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JAS. A. MORTON & SONS, 1701 LAURENS | | | | 25a. DATE RECD. BY REGISTRAR MAY 27 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #238 Film G567 5/20/82 re

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|---|---|---|--|--------------------------------|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| CHARLES F. GATEWOOD | | | | May 9, 1982 | | 7:00 P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. |
| Male | White | March 18, 1921 | | 61 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | USA | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Good Samaritan Hospital | | | Maintainer- Continental Can | | Company | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | | |
| Maryland | | | Baltimore | | 3211 Glendale Avenue | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | |
| James R. Gatewood | | | Bessie Lewis | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| Yes | | WW II 229 30 2950 | | Townes Funeral Home, Danville, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Presumed MI</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Squamous cell lung cancer</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <u>I</u> (the hospital) attended the deceased from <u>4/5/82</u> 19 <u>82</u> to <u>5/1/82</u> 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>4/5/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Peter A. O'Dwyer</u> | | <u>MD</u> | | | | <u>5/10/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Peter A. O'Dwyer, M.D. | | Loch Raven V.A. Hospital, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Removal | | 5/11/82 | | Greenhill Cemetery | | Danville, Virginia | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Henry W. Jenkins & Sons Co.
4905 York Road Balto., Md. 21212 | | MAY 11 1982 | | <u>James J. Nathan</u> | | | |

4002 York Road, Baltimore, Md. 21212
Henry W. Johnston & Sons Co.

Frederick, Md. Greenhill & Sons, Inc.

Robert A. Greenhill, M.D., 4002 York Road, Baltimore, Md.

[Faint, illegible handwritten text, possibly a signature or address, with a circular stamp or logo visible on the left side.]

Yess, Wm. II, 4002 York Road, Towson, Md. 21204, Baltimore, Md.

James E. Greenhill, 4002 York Road, Towson, Md. 21204, Baltimore, Md.

Maryland, Baltimore, Md. 21204, Towson, Md. 21204, Baltimore, Md.

Baltimore, Md. 21204, Towson, Md. 21204, Baltimore, Md.

Virginia, Baltimore, Md. 21204, Towson, Md. 21204, Baltimore, Md.

Virginia, Baltimore, Md. 21204, Towson, Md. 21204, Baltimore, Md.

Virginia, Baltimore, Md. 21204, Towson, Md. 21204, Baltimore, Md.

Virginia, Baltimore, Md. 21204, Towson, Md. 21204, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and one of the following must be completed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 2 0 6 3 | | | |
|---|--|---|--|---|--|---|--|
| FOR
1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
GERAGHTY, LENA C. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
May 21/82 | | 2b. HOUR
8:59 P.M. | |
| 3. SEX
FEM | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
6-25-29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS | |
| 7a. BIRTHPLACE
(COUNTRY) STATE OR FOREIGN
PA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
REL. NURSE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
3826 GLENHORE AVE. | | 14. FATHER'S NAME FIRST MIDDLE LAST
HARRY SEITZ | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
DESNA WILSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-26-1371 | | 17. INFORMANT
FAMILY RECORDS | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Metastatic ADENOCARCINOMA of lung with KRUKENBERG Metastasis. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | (b) | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | (c) | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
8:59 P.M. 5 21 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Good Samaritan Hosp. | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
5601 Loch Raven Blvd. Baltimore MD 21239 | | | |
| 22a. I certify that this hospital attended the deceased from May 21 , 19 82 , to May 21 , 19 82 , that (1) we last saw the deceased alive on May 21 , 19 82 , and that (2) my opinion death occurred on the date and hour and from the causes stated above (1) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
ANGEL PONCE MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANGEL PONCE MD | | 22e. ADDRESS
5601 Loch Raven Blvd Baltimore MD 21239 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5-25-82 | | 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto Co MD | |
| 24. FUNERAL DIRECTOR NAME
Evans Funeral Chapel | | ADDRESS
1800 Harbor Rd | | 25a. DATE RECEIVED BY REGISTRAR
MAY 28 1982 | | SIGNATURE
Theresa J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For any be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|--|--|---|-----------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 2 0 6 4 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| Frank Gerstung | | | | | May 18 82 7:14 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| Male | | Cauc. | | 12 25 1903 | | 78 YRS | | MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Md. | | U.S.A. | | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | JOHNS HOPKINS HOSPITAL | | | | | | Telephone | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Charles Gerstung | | | | | Agnes Peschel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | | 215-03-9660 | | Marie Gerstung 23 N. Kenwood Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Lung Cancer | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| Sepsis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 18 19 82 to May 18 19 82, that (I) (we) last saw the deceased alive on May 18 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If "we" did, did not view the body after death.) | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| J.B. Bolger MD | | | | | | | May 18/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| BOLGER, Graeme | | | | | 600 Johns Hopkins Hospital St. Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | | |
| Cremation | | 5/21/82 | | Greenmount Cem. | | Baltimore | | Md. | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE RECEIVED BY REGISTRAR | | | | | |
| B. Dabrowski & Son 2818 E. Baltimore St. | | | | | MAY 21 1982 | | | | | |

RECEIVED MAY 21 1962

U. S. Dept. of Justice
Federal Bureau of Investigation
Washington, D. C. 20535
MAY 21 1962

TO: SAC, NEW YORK
FROM: SAC, BALTIMORE
SUBJECT: [illegible]
RE: [illegible]

Enclosed for the New York Office are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM was prepared by the Baltimore Office on May 17, 1962, and is being furnished to you for your information and guidance. The LHM contains information regarding the activities of [illegible] and [illegible] in the Baltimore area.

Very truly yours,
Special Agent in Charge
Baltimore Office

Enclosed for the New York Office are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM was prepared by the Baltimore Office on May 17, 1962, and is being furnished to you for your information and guidance. The LHM contains information regarding the activities of [illegible] and [illegible] in the Baltimore area.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#1, FilmG601 3/26/B5 kam

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 6 5

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RABBI HYMAN FRIEDEL GEVANTMAN | | | 2a. DATE OF DEATH
MONTH 5 DAY 8 YEAR 82 | | | 2b. HOUR
2:00 M. | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 10 DAY 29 YEAR 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RABBI | | 12b. KIND OF BUSINESS OR INDUSTRY
RELIGION | | | |
| 13a. STATE
MD | | | 13b. COUNTY
BALT. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3303 GREENVALE RD | | | | |
| 14. FATHER'S NAME
FIRST ISAAC MIDDLE LAST GEVANTMAN | | | 15. MOTHER'S MAIDEN NAME
FIRST SHAINDEL MIDDLE LAST UNKNOWN | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
184-30-6045 | | 17. INFORMANT ADDRESS
MRS. CHARLOTTE GEVANTMAN 3303 GREENVALE RD. (21208) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 INTRACTABLE CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) PREVIOUS MYOCARDIAL INFARCTIONS
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
DIABETES Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4-29 , 19 82 , to 5-8 , 19 82 , that (1) (we) lost
saw the deceased alive on 5-8 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. Ordoqui MD | | | DEGREE MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
5/8/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. ORDOQUI MD | | | 22e. ADDRESS
SINAI HOSPITAL, BALT. MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
5-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY
(ANSHE EMUNAH) AITZ CHAIM | | 23d. LOCATION
CITY OR TOWN BALTIMORE COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS
NAME 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 12 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances VanNathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 6 6 | | | | |
|---|--|--|--|--|--------------------------|---|---|--|-----|--|------|---------------------|----------|--|
| FOR
1. STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| MARGUERITE WIGHT GEYER | | | | | 5 | | 19 | | 82 | | 10 | | 30 M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Female | | White | | 7 MONTH 24 DAY 1893 | | 88 YRS | | MONTHS | | DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Baltimore | | St. Agnes Hospital | | | | Housewife | | --- | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | |
| Maryland | | | | | | | | | | A.A. Co. | | Hanover | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| George O. High | | | | | Mary Cassidy | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| NO | | | | | 212-54-9782 | | Evelyn L. Pitzinger 7209 Ridge Road 21076 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiorespiratory arrest | | | | | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) Acute M.I. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | |
| Nagar Vaywala | | | | MD | | | | 5/20/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | |
| Dr. Vaywala | | | | 301 St. Agnes Medical Center | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | |
| Burial | | | | 5/22/82 | | Loudon Park Cemetery | | | | Baltimore COUNTY Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | MAY 24 1982 | | | | [Signature] | | | | |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

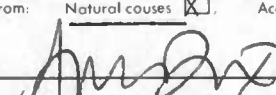
8 2 1 2 0 6 7

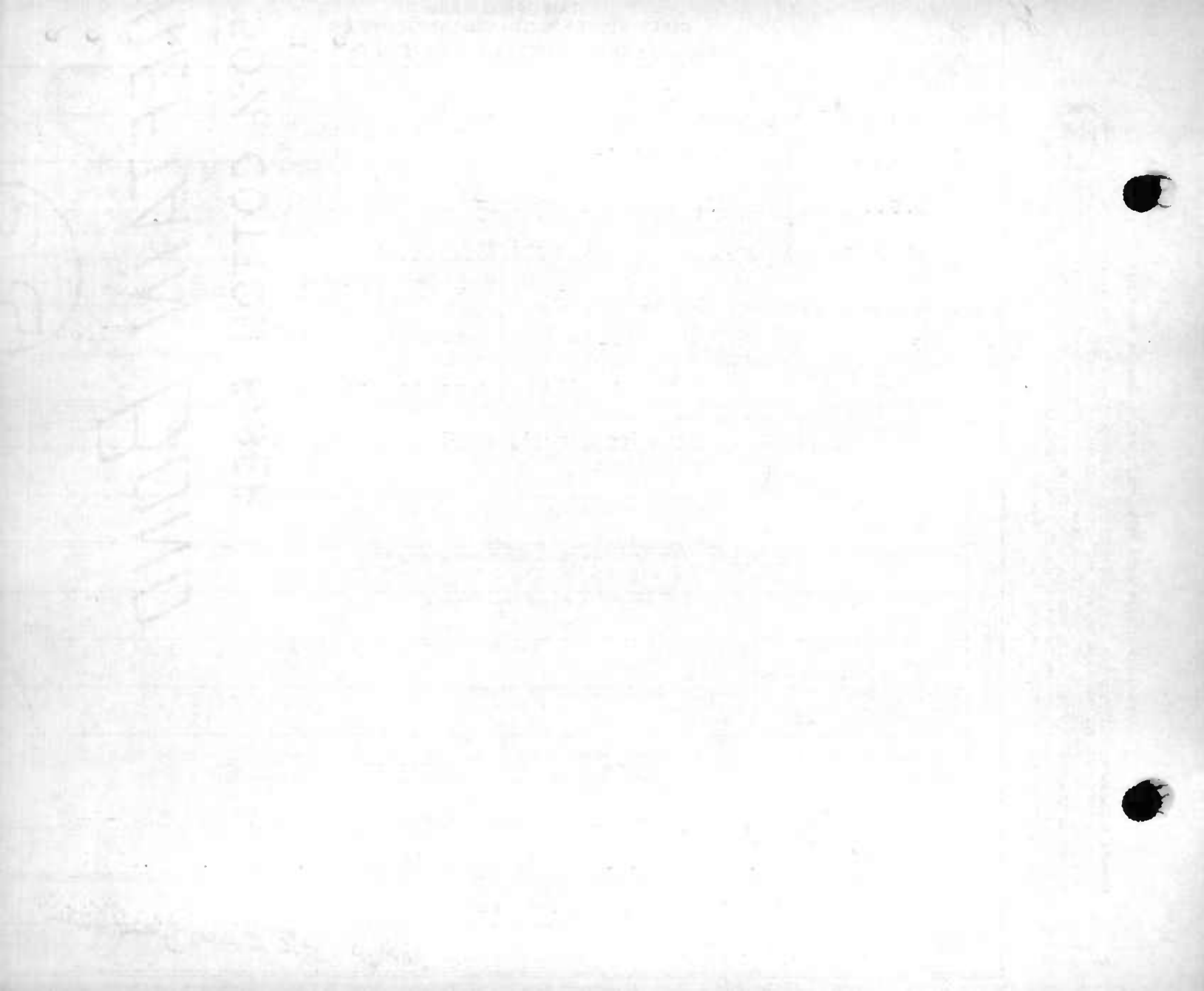
REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|-----------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Anna | | P | | Giddings | | | | 5 | | 24 | | 82 | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Female | | White | | 10 19 1898 | | 83 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Virginia | | USA | | | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 1534 Baldwin St. | | Housewife | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | -- | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1534 Baldwin St. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Lee | | Cameron | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 211-20-8985 | | Mrs. Vivian Kinlein | | 1534 Baldwin St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 4039 | | Heart failure | | Hypertensive Cardio-Cerebral disease. | | | | 20 Years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 5-8 19 60 to 5-24 19 82, that (I) saw the deceased alive on 5-15 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | |
| REUBEN HOFFMAN, M.D. | | ATTENDING PHYSICIAN | | MEDICAL <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 5-24-82 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| REUBEN HOFFMAN, M.D. | | 846 W. 36th St. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 5/26/82 | | Moreland Mem. Pk. | | Balto. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| A. Alan Seitz Funeral Home 3818 Roland Ave. | | MAY 26 1982 | | [Signature] | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12068 | |
|--|-------------------------|--|---|---|--------------------------------|---|--|---|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM J. GILBERT | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5 3 19 82 | | 2b. HOUR 4:55 | | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR 3 4 19 18 | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
5 3 19 82 | | 2d. HOUR 4:55 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2121 Etting Street | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Johnny Gilbert | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Frances Wilson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
246-14-4349 | | 17. INFORMANT ADDRESS
Narcott Funeral Home | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 5-3-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Ayden Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ayden N.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 E. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 5 1982 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

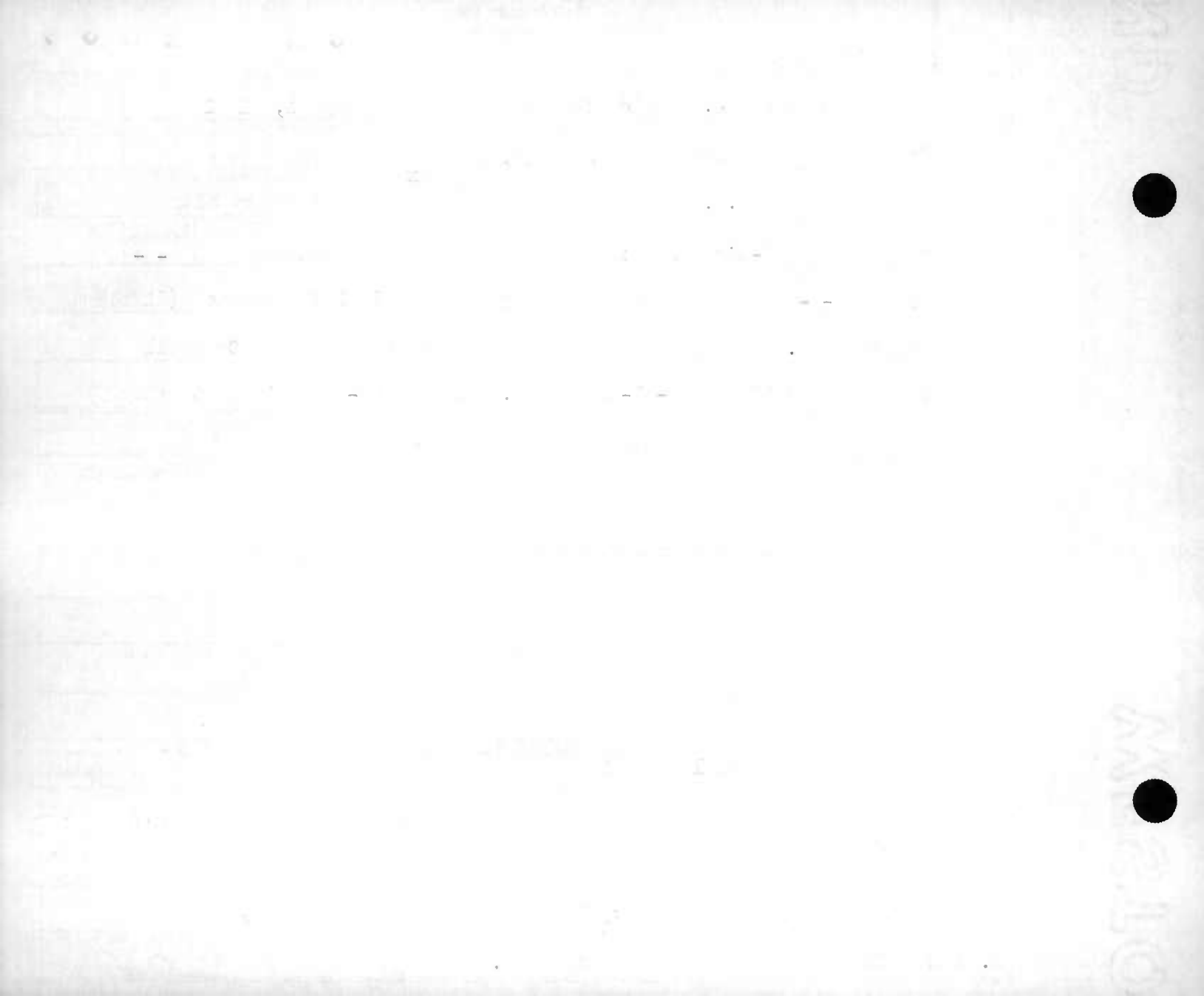
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 2 0 6 9
REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles J. Gildenfenney | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 1, 1982 | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 15, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bel-Air Convalesarium | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 15. KIND OF BUSINESS OR INDUSTRY
-- -- | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3622 Elm Avenue (21211) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William B. Gildenfenney | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Creswell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT ADDRESS
Mrs. Sylvia Kirk-East 30th St (apt 305) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CANCER of Stomach</u>
1519
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 21, 1982</u> to <u>MAY 1, 1982</u> , that (I) (we) last saw the deceased alive on <u>May 1, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>L. Boas MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
May 2, 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. BOAS MD | | | | 22e. ADDRESS
50 SCOTT ADAM RD Cockeysville MD 21030 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodbury Cemetery
LORRAINE PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz Funeral Home | | | | ADDRESS
3818 Roland Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 4 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

BP

DHMH-16 20M
(VRA 15, 4) 7/78



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 7 0

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ida Mae Gilyard | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 1 1982 | | 2b. HOUR
M
 |
| 3. SEX
female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
2 27 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city
MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2788 Tivoly Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | 13b. COUNTY
 | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2788 Tivoly Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Rev James Lewis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Georgia Wilson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-28-8487 | | 17. INFORMANT
ADDRESS
Wardell Gilyard 2788 Tivoly Avenue | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular Arrhythmia
4149
DUE TO, OR AS A CONSEQUENCE OF
(b) Ischemic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Congestive Heart Failure

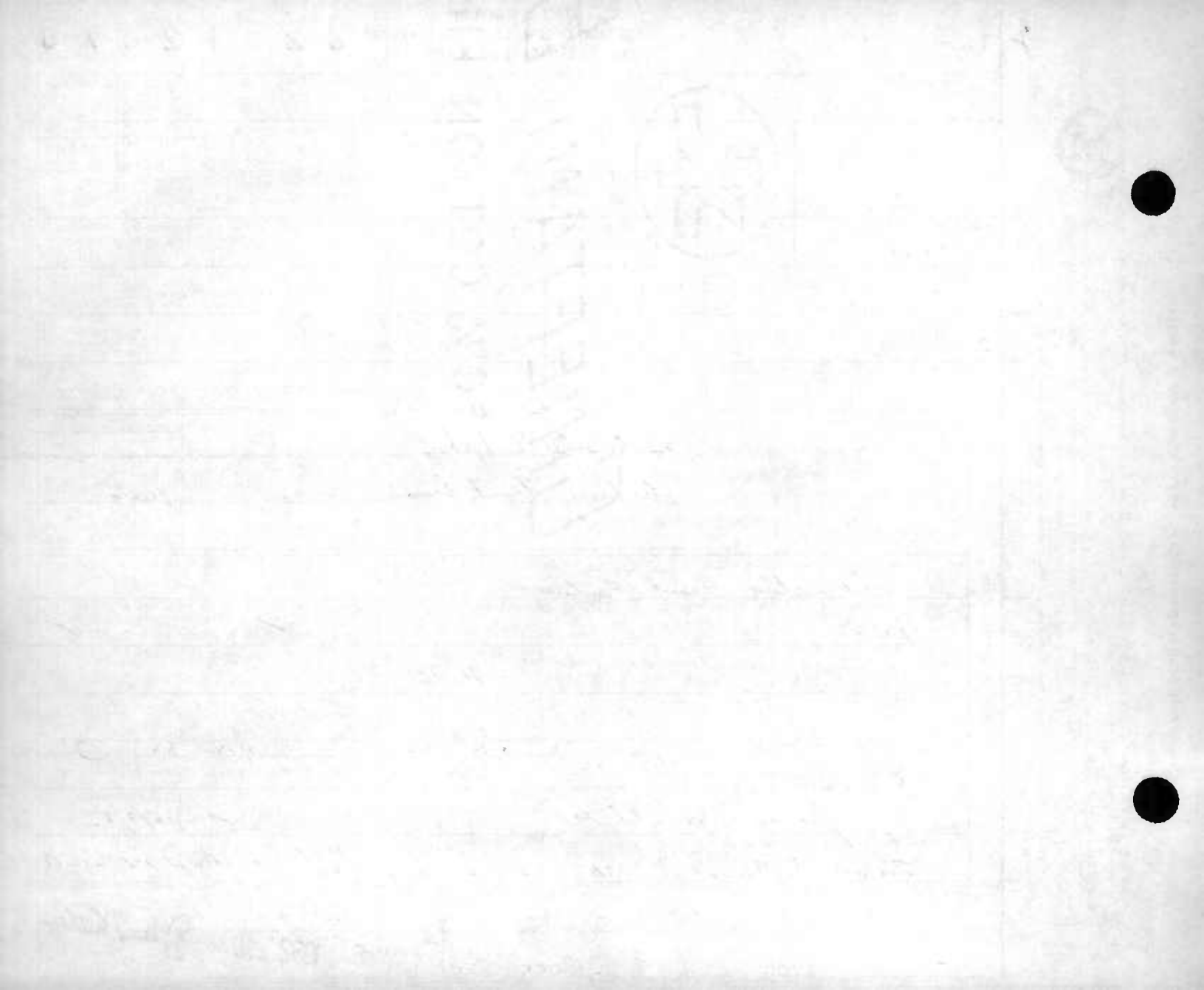
| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION
NONE | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
NONE | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
 | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/1, 1982</u> to <u>4/14, 1982</u> , that (I) (we) lost saw the deceased alive on <u>4/14, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | |
| 22b. SIGNATURE
<u>James C Jarrell MD</u> | DEGREE
MD | | 22c. DATE SIGNED
5/3/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>James C Jarrell MD</u> | 22e. ADDRESS
<u>Union Memorial Hosp Baltimore, MD 21218</u>
<u>201 E Univ. Pkwy</u> | | |

| | | | |
|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/7/82 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)
5 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 7 1
REG. NO. | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) YETTA FIRST MIDDLE LAST GINSBURG | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/23/82 | | | 2b. HOUR 0100a | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 19, 1906 | | 6. AGE IN YEARS LAST BIRTHDAY 76 | | IF UNDER 1 YEAR IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER | | 12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTING | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> XX NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3710 KINGWOOD SQ. #21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LOUIS GINBERG | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH GINSBERG | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-01-0145 | | 17. INFORMANT MANUEL GINSBERG 3710 KINGWOOD SQ. BALTO., MD 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST. (b) DISSEMINATED CARCINOMATOSIS. (c) OVARIAN OR MELANOMA? | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 5/17/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Myerson DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/23/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myerson | | | | 22e. ADDRESS SINAI HOSP. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAY 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY AGUDAS ACHIM ANSHE STARD ROSEDALE | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD | | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 28 1982 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 7 2 | |
|--|--|--|--|--|---|--|---|--|---------|--|--|
| 1 - FOR STATE REGISTRAR | | | CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| NELLIE MARIE GISE | | | | | | 05/30/82 | | | | 1 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | Caucasian | | MONTH DAY YEAR | | 85 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Kentucky | | U.S.A. | | | | Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Bel Air Convelesarium | | | | Clerk | | Railroad | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | | |
| Maryland | | | Baltimore | | Catonsville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | 6005 Central Avenue | | | | | |
| Joseph Lane | | | Mattie Henson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | N/A | | 217-22-6537 Muriel Terrall, 6116 Bel Air Road | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) 4360 SEPSIS | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) OLD CVA | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, SENILE DEMENTIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 1a) HOME, STREET, FACTORY, OFFICE, FARM, ETC. | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 21g. I certify that (I) (this hospital) attended the deceased from September 28, 1978 to May 30, 1982 that (we) last saw the deceased alive on May 29, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE | | | DEGREE | | | 22b. DATE SIGNED | | | | | |
| Walter R. Hepner | | | ATTENDING PHYSICIAN | | | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 5/30/82 | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22d. ADDRESS | | | | | | | | |
| WALTER R. HEPNER | | | 6116 Bel Air Road | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Cremation | | | 6/2/82 | | Westview Memorial Park | | CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | Catonsville, Baltimore, Md | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE RECD. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME | | | WOODLAWN MEMORIAL FH | | | | | | | | |
| Walter E. Fisher | | | 6111 Windsor Mill Rd | | | | | | | | |

[illegible]

REV. 6-20

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GRILL

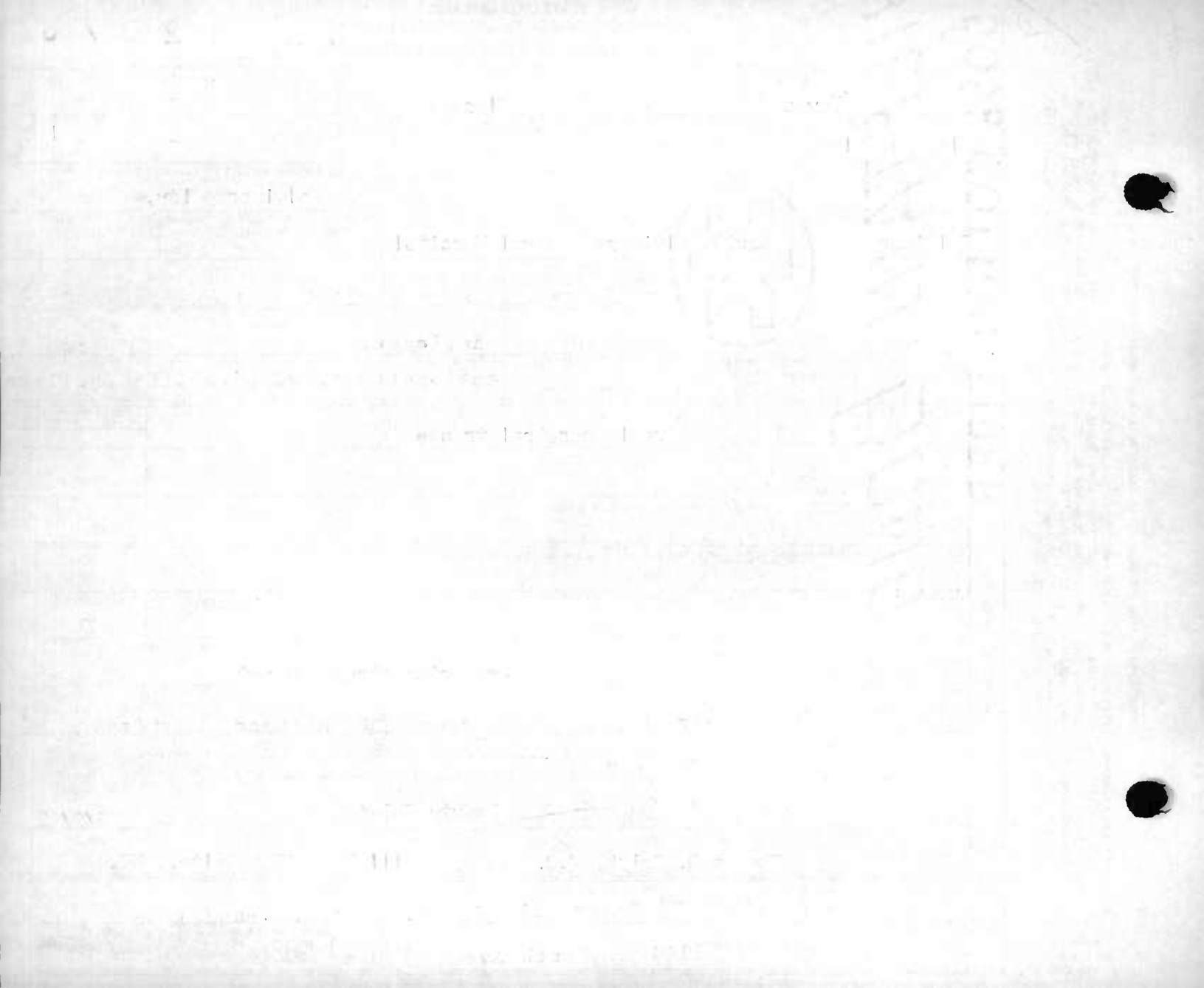
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INDEX

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 2 0 7 3 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Tavon L. Glascoe | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 8 19 82 | |
| 2. SEX Male 4. RACE Black 5. DATE OF BIRTH (MONTH DAY YEAR) 9 15 79 6. AGE (IN YEARS LAST BIRTHDAY) 2 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 5 8 19 82 2d. HOUR 1:29P | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md 9. CITIZEN OF WHAT COUNTRY? USA 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 11. CITY OR TOWN OF DEATH Baltimore 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | | | | | | | | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 14. KIND OF BUSINESS OR INDUSTRY | |
| 15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Md 16b. COUNTY Baltimore 16c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 16d. STREET ADDRESS 2605 Spellman Road Apt 2A | | | | | | | | | | | |
| 17. FATHER'S NAME (FIRST MIDDLE LAST) Michael Glascoe 18. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Antionette Pinnick | | | | | | | | | | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 19b. SOCIAL SECURITY NO. 19c. INFORMANT ADDRESS Antionette S. Pinnick 2605 Spellman | | | | | | | | | | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cranio cerebral trauma
DUE TO, OR AS A CONSEQUENCE OF
(b) 8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 21a. DATE OF OPERATION 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 21c. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | |
| 22a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 12 55 P.M. 5 8 19 82 Pedestrian struck by auto | | | | | | | | | | | |
| 22b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22c. PLACE OF INJURY (FARM, ETC.) street 22d. LOCATION (CITY OR TOWN COUNTY STATE) 2600 Round Rd Balitmoee City Md | | | | | | | | | | | |
| 23. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 5/9/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn ST. Balto., MD. | | | | | | | | | | | |
| 24. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 24b. DATE 5/12/82 24c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem 24d. LOCATION (CITY OR TOWN COUNTY STATE) Anne Arundel Co Md | | | | | | | | | | | |
| 25. FUNERAL DIRECTOR Willia C. March F/H 1101 E. North Ave 25b. DATE REC'D. BY REGISTRAR MAY 11 1982 25c. REGISTRAR'S SIGNATURE Frances Jan Nathan | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 7 4 | |
|--|--|---|--|---|---|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
CARRIE MAY GLASS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 22, 1982 | | | 2b. HOUR
6:03A | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
10 - 29 - 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING MFG. | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
622 N. ROBINSON ST. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOHN A. GLASS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY E. EMERSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
212.03.0232 | | 17. INFORMANT ADDRESS
RICHARD F. HOOD 6661 Loch Hill RD. 21239 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CONGESTIVE HEART FAILURE
(c) CORONARY ARTERY DISEASE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45 min.
3 mos.
3 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 82 , to 5/22 , 19 82 , that (I) (we) last saw the deceased alive on 5/22 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Kevin R. Fox, M.D. | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KEVIN R. FOX | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | | 23b. DATE
5/24/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN MOUNT CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

11

THE UNIVERSITY OF CHICAGO
LIBRARY
1200 EAST 58TH STREET
CHICAGO, ILL. 60637
TEL. 733-4331
FAX 733-4331
WWW.CHICAGO.EDU
1200 EAST 58TH STREET
CHICAGO, ILL. 60637
TEL. 733-4331
FAX 733-4331
WWW.CHICAGO.EDU

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 7 5

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RAYMOND J. GOLDEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
05 19 82 | | 2b. HOUR
M
M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
02 13 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2419 BANGER STREET, 21230 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MAINTENANCE | | 12b. KIND OF BUSINESS OR INDUSTRY
REALTY CO. |
| 13a. STATE
MARYLAND | | 13b. COUNTY
-- | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES GOLDEN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET FUCHS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-01-5899 | | 17. INFORMANT
ADDRESS
WALTER PARKER, JR. 2610 RITTENHOUSE AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4100
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
8-9 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Calcipic Aortic Stenosis | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from March 19 73 to 5-19 19 82 , that (I) (we) lost saw the deceased alive on 5-4 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Kyle Y. Swisher Jr MD | | | | 22c. DATE SIGNED
5-20-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KYLE Y. SWISHER, JR., M.D. | | | | 22e. ADDRESS
St. Agnes Medical Center 2nd Floor | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
05-22-82 | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE MEM. PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELKCRIDGE HOWARD MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
MAY 21 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

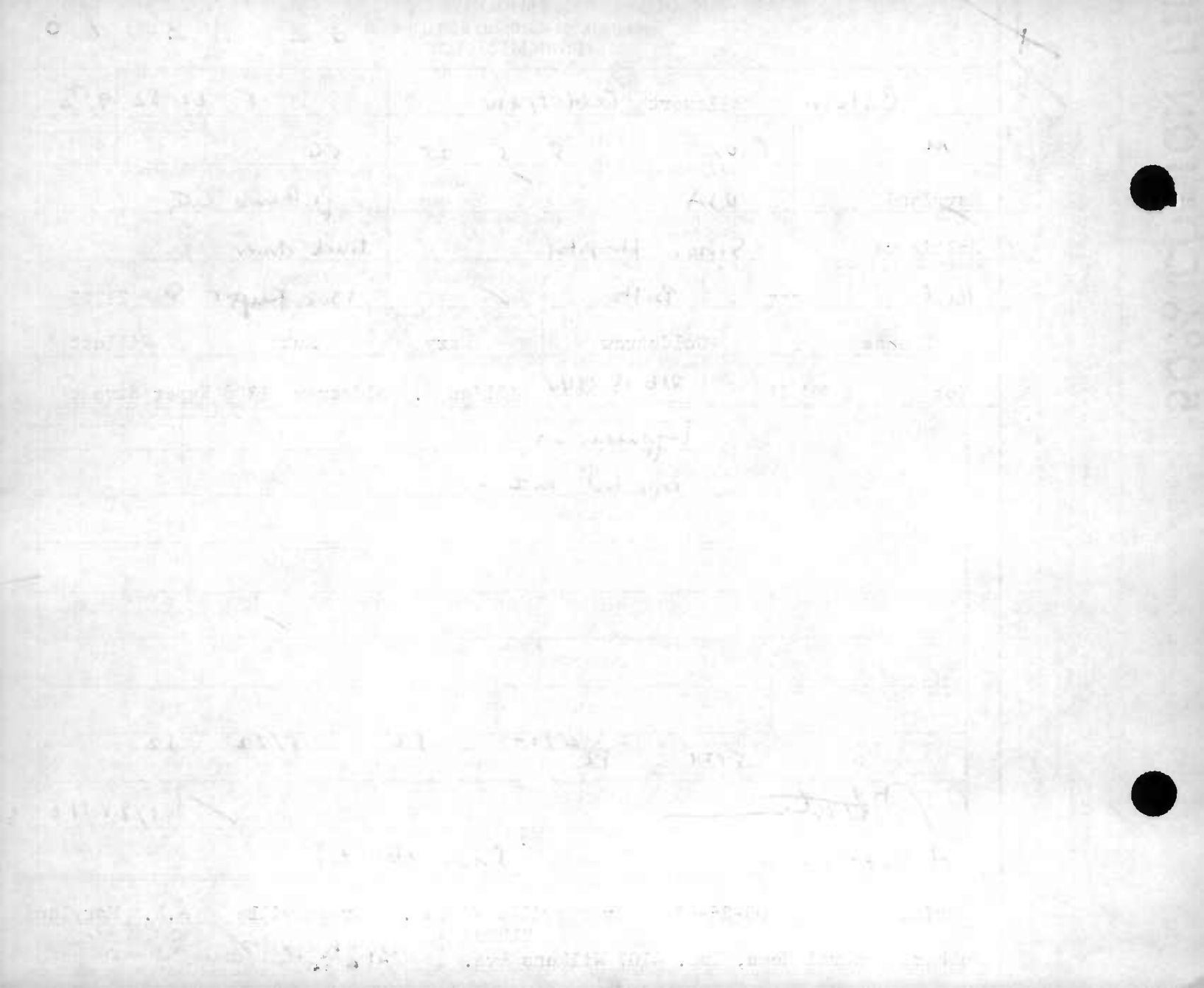
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 7 6

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Calvin Ellsworth Goldstraw | | 2a. DATE OF DEATH MONTH DAY YEAR
5 22 82 | | 2b. HOUR
9⁵⁵A M | |
| 3. SEX
M | | 4. RACE
CAV. | | 5. DATE OF BIRTH MONTH DAY YEAR
8 5 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck driver | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
1308 Kuper St. | | 13f. ZIP CODE
21223 | | 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Goldstraw | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Ruth Willett | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
216 18 3344 | | 17. INFORMANT
Lillian M. Goldstraw | | 17. ADDRESS
1308 Kuper Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Repeated M.I.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 82 , to 5/22 , 19 82 , that (I) (we) last saw the deceased alive on 5/22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. Hettelman | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Hettelman | | 22e. ADDRESS
Sinai Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
05-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville VA Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville A.A. Maryland | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. | | ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 2 0 7 7 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| DONALD Ducane GOODE | | | | | 5/21/82 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| MALE | | BLACK | | 8/4/31 | | 50 | | 5:50P ^M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | U. S. A. | | | | BALTIMORE CITY | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | STUA, HOSPITAL | | | | teacher | | Balto. City | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE: MD 13b. COUNTY: BALTIMORE 13c. CITY OR TOWN: Randallstown | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| James Goode | | | | | Adell Austin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| No | | | | | 217-24-9615 | | Baltimore Maryland 21133 | | |
| | | | | | Mrs. Beverley B. Goode 19 Hobart Ct. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE ANTEROSEPTAL MYOCARDIAL INFARCTION | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. YEARS | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| HYPERTENSION, INSULIN DEPENDANT DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/21, 1982, to 5/21, 1982, that (I) (we) lost saw the deceased alive on 5/21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | | |
| Bernard F. Kozlousky MD | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> HOUSE STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 5/21/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| BERNARD F. KOZLOUSKY | | | | | CLOSAI HOSPITAL, BALTIMORE MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 5/26/82 | | Arbutus Mem. Park | | Baltimore County, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Baltimore, Maryland 21216 | | | | | MAY 27 1982 | | James J. [Signature] | | |
| HEBERT E. NUTTER, Funeral Home 3035 W. NORTH AVE. | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

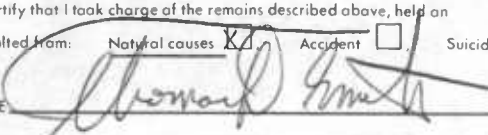

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|------------------|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mamie Goodman | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
5 21 19 82 | | | | 2b. HOUR
9 A | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
12 22 08 ^{AR} | 6. AGE (IN YEARS)
73 ^{YRS.} | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
5 21 19 82 | | 2d. HOUR
A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED
WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1913 Kennedy Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Ballard | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Ballard | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
212-20-8367 | | 17. INFORMANT
ADDRESS
Anita Richardson 1913 Kennedy Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma</u>
1991
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | | | DATE SIGNED
5/21/82 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | ADDRESS
111 Penn ST. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 26 1982 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card in poppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a case.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RALPH Abijah GOODWIN | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 13, 1982 | | 2b. HOUR
07:34AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 1, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Iowa | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Professor | | 12b. KIND OF BUSINESS OR INDUSTRY
USNA | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Cyrus Randolph Goodwin | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Harriett A. Williams | | 13e. STREET ADDRESS
126 Sumner Road 21401 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1944-1945 624-05-1502 | | 17. INFORMANT
Margaret C. Goodwin | | ADDRESS
Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4254 IMMEDIATE CAUSE (a) Cardiovascular arrest
DUE TO, OR AS A CONSEQUENCE OF
1(b) Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Cerebrovascular accident | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5/13 P.M. 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (If (this hospital) attended the deceased from 4/27 , 19 82 , to 5/13 , 19 82 , that (we) lost saw the deceased alive on 5/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gelman | | | | 22e. ADDRESS
John Hopkins | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis AA MD | |
| 24. FUNERAL DIRECTOR
NAME
John M. Taylor & Sons | | | | ADDRESS
Annapolis MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 6 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

Abraham Lincoln
White House
Washington D.C.
February 12, 1862
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the
land in the State of Illinois, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,
Abraham Lincoln
President of the United States

Very respectfully,
Abraham Lincoln
President of the United States



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 2 0 8 0 | |
|--|--|---|--|---|---|---|--|--|--|------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DORIS GORDON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 05 11 82 | | | 2b. HOUR
6:18 PM | | | |
| 3 SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR 06 04 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hosp of Balto | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
US. GOVERNMENT | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6944 GLENHEIGHTS AVE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
OSCAR KATZEN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
REBECCA KARLOFF | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216 14 0282 | | 17. INFORMANT
DAVID GORDON
6944 GLENHEIGHTS AVE. BALTO., MD 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CA OF STOMACH
1519
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 82 , to 5/11 , 19 82 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harvey Rosen | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/11/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harvey Rosen | | | | 22e. ADDRESS
SINAI HOSPITAL OF BALTO | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAY 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982
25b. REGISTRAR'S SIGNATURE
James J. Fisher | | | | | |

1000

1000

1000



1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 8 1 | |
|--|--|--|--|---|-----------------------------------|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | REG. NO. | |
| FIRST MARY A. MIDDLE LAST GORSUCH | | MONTH 5 DAY 18 YEAR 82 | | 2b. HOUR 9:30 P.M. | |
| 3. SEX FEMALE | 4. RACE CAUC | 5. DATE OF BIRTH MONTH 10 DAY 15 YEAR 09 | | 6. AGE 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. City MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. CHARLES GEN. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD. | | 13b. COUNTY | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 5401 CATALPHAMAR | |
| 14. FATHER'S NAME FIRST ? MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST ? MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES NAVY | | 16b. SOCIAL SECURITY NO. ? | | 17. INFORMANT DAUGHTER ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) SEPTICEMIA | | | | | |
| 5990 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) URINARY tract infection | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/15/82 to 5/18/82, that (I) (we) lost saw the deceased alive on 5/18/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Marcos B. Galicia Jr MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA Jr MD | | 22e. ADDRESS North CHARLES GEN. Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY BALTO. CEM. | |
| 23d. LOCATION (CITY OR TOWN) BALTO. MD. | | 23e. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR Paul E. Chomatos | | ADDRESS 3617 Chestnut Ave. | | 25a. DATE FILED BY REGISTRAR 5/25/82 | |

1 2 3 4 5 6 7 8 9 10 11 12

13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500

501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600

601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700

701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800

801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900

901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100

1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194 1195 1196 1197 1198 1199 1200

1201 1202 1203 1204 1205 1206 1207 1208 1209 1210 1211 1212 1213 1214 1215 1216 1217 1218 1219 1220 1221 1222 1223 1224 1225 1226 1227 1228 1229 1230 1231 1232 1233 1234 1235 1236 1237 1238 1239 1240 1241 1242 1243 1244 1245 1246 1247 1248 1249 1250 1251 1252 1253 1254 1255 1256 1257 1258 1259 1260 1261 1262 1263 1264 1265 1266 1267 1268 1269 1270 1271 1272 1273 1274 1275 1276 1277 1278 1279 1280 1281 1282 1283 1284 1285 1286 1287 1288 1289 1290 1291 1292 1293 1294 1295 1296 1297 1298 1299 1300

1301 1302 1303 1304 1305 1306 1307 1308 1309 1310 1311 1312 1313 1314 1315 1316 1317 1318 1319 1320 1321 1322 1323 1324 1325 1326 1327 1328 1329 1330 1331 1332 1333 1334 1335 1336 1337 1338 1339 1340 1341 1342 1343 1344 1345 1346 1347 1348 1349 1350 1351 1352 1353 1354 1355 1356 1357 1358 1359 1360 1361 1362 1363 1364 1365 1366 1367 1368 1369 1370 1371 1372 1373 1374 1375 1376 1377 1378 1379 1380 1381 1382 1383 1384 1385 1386 1387 1388 1389 1390 1391 1392 1393 1394 1395 1396 1397 1398 1399 1400

1401 1402 1403 1404 1405 1406 1407 1408 1409 1410 1411 1412 1413 1414 1415 1416 1417 1418 1419 1420 1421 1422 1423 1424 1425 1426 1427 1428 1429 1430 1431 1432 1433 1434 1435 1436 1437 1438 1439 1440 1441 1442 1443 1444 1445 1446 1447 1448 1449 1450 1451 1452 1453 1454 1455 1456 1457 1458 1459 1460 1461 1462 1463 1464 1465 1466 1467 1468 1469 1470 1471 1472 1473 1474 1475 1476 1477 1478 1479 1480 1481 1482 1483 1484 1485 1486 1487 1488 1489 1490 1491 1492 1493 1494 1495 1496 1497 1498 1499 1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 8 2 | |
|---|--|---|--|---|--|
| 1 - STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| I. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| Nellie Gosnell | | | | 5-2-82 5:59 AM | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
6 23 94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Carroll Co MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City of Baltimore MD | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | | | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Samuel R Neubottom | | 15. MOTHER'S MAIDEN NAME
Louise | | 13e. STREET ADDRESS
325 Holly Manor Rd | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
M. IONNO Holliday 325 Holly Manor Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
7070
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Multiple Decubiti Ulcers.
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 04-07, 19 82, to 05-02, 19 82, that (we) lost saw the deceased alive on 5-2-82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Sissy Awoke | | DEGREE
MD. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sissy Awoke | | 22e. ADDRESS
Lutheran Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
White Rock Church | |
| 24. FUNERAL DIRECTOR
NAME
Mansueti | | 23d. LOCATION
CITY OR TOWN
Carroll Co MD | | 23e. STATE | |
| 24. FUNERAL DIRECTOR
ADDRESS
630 1/2 9th Ave SE | | 25a. DATE REC'D. BY REGISTRAR
MAY 4 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Smith | |



WINDY

WINDY

COLLON-BEER

MAY 1 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 1 2 0 8 3 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Edgar B Graham</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>5 25 82</i> | | 2b. HOUR MIN
<i>4 15 A M</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>June 13 1894</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN
<i>87</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Good Samaritan</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Comptroller</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE
<i>Md. Balto.</i> | | 13c. CITY OR TOWN
<i>Towson</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>8601 Drumwood Rd.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Ellis C. Graham</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Emma Baker</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
<i>WW 1</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Robert Erhardt Same</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinomatosis, Liver</i>
<i>1531</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Transverse Colon</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | |
| 19a. DATE OF OPERATION
<i>5/14/82</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Poor</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-29</i> , 19 <i>82</i> , to <i>5/15</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>5/25/82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>T. Lin</i> | | | | DEGREE
<i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>5/25/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>T. LIN</i> | | | | 22e. ADDRESS
<i>Good Samaritan Hospital</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>5-28-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Moreland Mem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Balto. Balto. Md.</i> | |
| 24. FUNERAL DIRECTOR NAME
<i>H. W. Jenkins & Sons Co., Balto., Md.</i> | | | | 25a. DATE RECEIVED BY REGISTRAR
<i>MAY 25 1982</i> | | | |

1000

2

12-10-88 12:25 YAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 8 4 | | | | | |
|---|--|------------------------------|--|---|--|--|--|--|--|--|--|-----------------------------------|--|----------|--|
| 1. FOR
STATE
REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| FIRST MIDDLE LAST
Willie Davis Graham | | | | 5 | | 17 | | 82 | | 6 | | 16 | | P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| Male | | Black | | MONTH DAY YEAR
7 28 24 | | 57 YRS | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| GA | | USA | | | | Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | North Charles General | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4813 Park Heights Ave. | | | | | | | |
| MD | | | | Baltimore | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | |
| - | | | | Mary Jones | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| No | | | | 226-36-0487 | | Bertha Graham 4813 Park Heights Ave. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Bilateral at cell</u>
(c) <u>bronchogenic ca</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 mos | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to <u>May 17</u> , 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>May 17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE
<u>F. C. CAGUIN, MD</u> | | | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/17/82</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | |
| F. C. CAGUIN, MD | | | | 230 E. 25th ST Baltimore MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | | 5/22/82 | | Arbutus Mem. Park | | Baltimore Co. | | MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | MAY 19 1982 | | <u>[Signature]</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMM - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 8 5 | | | |
|---|--|---|--|---|--|--|--|
| FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST Harry MIDDLE William LAST Granruth
HARRY WILLIAM GRANRUTH | | | | 2a. DATE OF DEATH MONTH 5 DAY 9 YEAR 82 2b. HOUR
5 9 82 9:25 PM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH July DAY 1 YEAR 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Consulting Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired-Emp. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Catonsville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS
225 Stonewall Road | | | | 13f. ZIP CODE
21228 | | | |
| 14. FATHER'S NAME
FIRST Harry MIDDLE G. LAST Granruth | | | | 15. MOTHER'S MAIDEN NAME
FIRST Edith MIDDLE Smith LAST Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
212-07-7238 | | 17. INFORMANT
Lorain S. Annis ADDRESS
Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Renal Failure
4149 DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Ischemic Heart Disease | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-1 , 19 82 , to 5-9 , 19 82 , that (I) (we) last saw the deceased alive on 5-9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Laurence S. Zeidman MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lawrence S. Zeidman | | | | 22e. ADDRESS
900 CATON AVE BALTIMORE MD 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore | |
| 24. FUNERAL DIRECTOR
NAME Witzke Funeral Home P.A. ADDRESS
1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1982 25b. REGISTRAR'S SIGNATURE
James J. Martin | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 8 6

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HENRY GRAUL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 12 82
7b. HOUR
16:55 AM | | |
| 3. SEX
M | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 19 1887 | 6. AGE (IN YEARS LAST BIRTHDAY)
94
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto, Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Balto. Cty. Gen. Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Various | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
315 Ingleside Ave. 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wilhelm Graul | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Lassahn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
220-01-5834 | 17. INFORMANT ADDRESS
Earl F. Graul, 1008 Gladway Rd. 21220 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) LEFT LOWER LOBE PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) 4810
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
OLD AGE | | | | | |
| 19a. DATE OF OPERATION
9 9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 27a. SIGNATURE
Hafeez A Syed | | DEGREE | | 27b. DATED
5/12/82 | |
| 27a. PHYSICIAN'S NAME (TYPE OR PRINT)
HAFAEEZ A SYED | | 27c. ADDRESS
BALTIMORE COUNTY GEN HOSP | | 27d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
5-15-82 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Essex Balto. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Lassahn Funeral Home | | ADDRESS
7401 Belair Rd | | 25. DATE REC'D. BY REGISTRAR
MAY 20 1982 | |
| 26. REGISTRAR'S SIGNATURE
James Van Natten | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

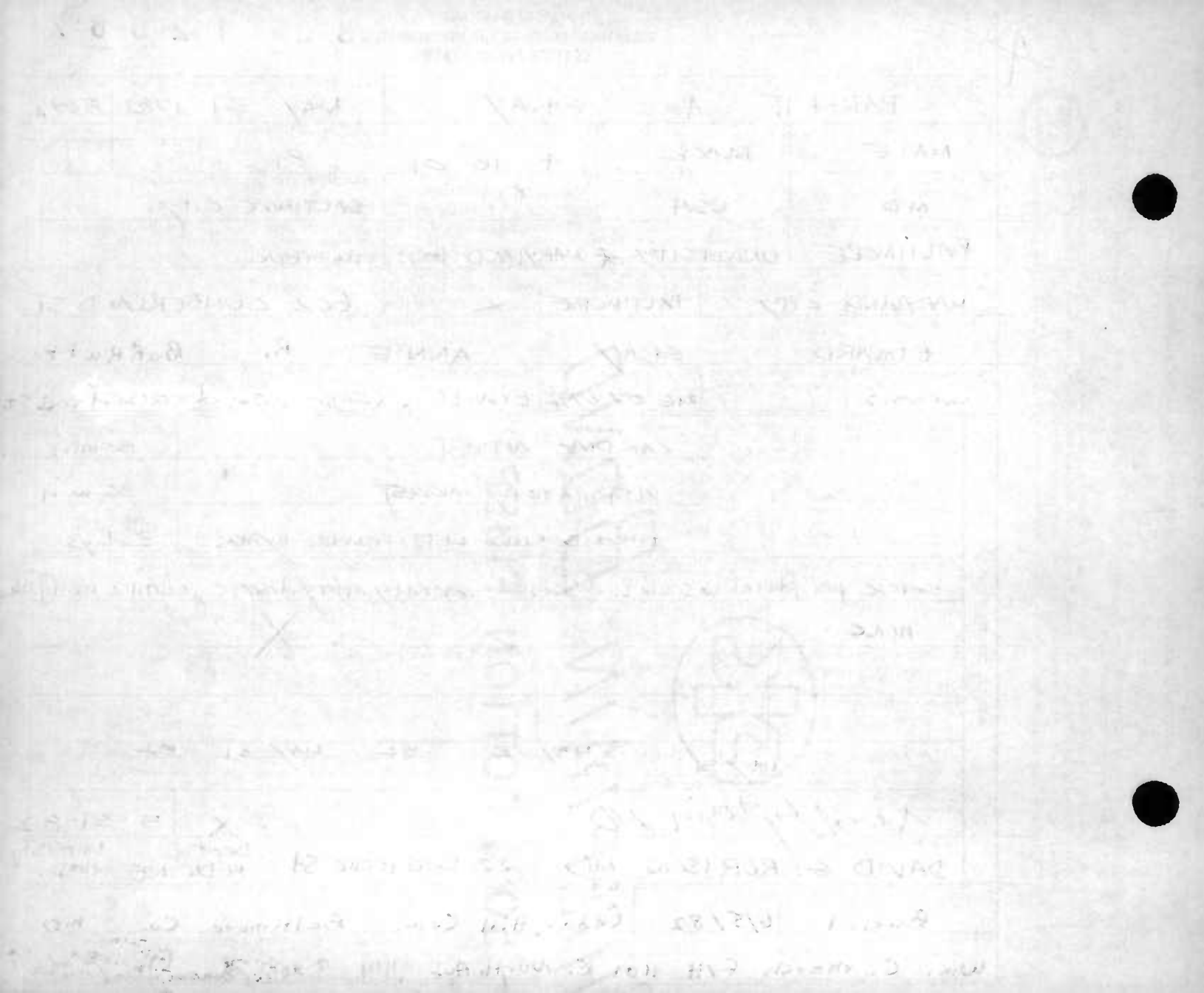
DHMH-16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 8 7 | |
|---|--|--|--|---|--|
| FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
BARRETT A. GRAY | | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 31 1982 | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
4 16 01 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
81 YRS. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY of MARYLAND HSP. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY. MD. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
CITY | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EDWARD GRAY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNIE K. BARRETT | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CHAUFFEUR | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
216 07 0792 | | 17. INFORMANT ADDRESS
Erma L. Gray 602 Cumberland St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (c) THROMBOSED LEFT FEMORAL BYPASS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4538
APPROX. INTERVAL BETWEEN ONSET AND DEATH
30 min
35 min
3 days | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
severe peripheral vascular disease, coronary artery disease, chronic renal failure | | | | | |
| 19a. DATE OF OPERATION
none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 28 , 19 82 , to MAY 31 , 19 82 , that (I) (we) last saw the deceased alive on MAY 31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
David G. Rorison MD | | DEGREE | | 22c. DATE SIGNED
5-31-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID G. RORISON MD | | 22e. ADDRESS
22 S. Greene St. Dept of Medicine Univ. Hsp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
6/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | 25a. DATE REC'D. BY REGISTRAR
JUN 3 1982 | |
| 25b. REGISTRAR'S SIGNATURE
James W. Kathan | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 0 8 8 | |
|---|--|---|--|---|---|---|--|--|--|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT M. GRAY | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 5/28/82 | | | 2b. HOUR
12:03 A | | | |
| 3. SEX
male | | 4. RACE
caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR 6/33/33 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Food | | | |
| 13a. STATE
MD | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2917 Eastern Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WALTER E. GRAY | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Powichrowska | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
213-32-3872 | | 17. INFORMANT ADDRESS
Walter E. Gray
2917 Eastern Ave, Baltimore, Md. | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) brainstem herniation
4273
DUE TO, OR AS A CONSEQUENCE OF
(b) Thromboembolic cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF
(c) chronic atrial fibrillation
Approximate interval between onset and death:
24 hrs
4 days
2-3 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/24 19 82 to 5/28 19 82 , that (I) (we) lost
saw the deceased alive on 5/28 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
George S. Bause, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/28/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE S. BAUSE | | | | 22e. ADDRESS
JOHN'S HOPKINS HOSPITAL
600 N. WOLFE, BALTO., MD 21205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
6-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Nicholas T. Matthews, 3021 Eastern Ave, Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 1 1982 | | | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Shane J. Smith | | | | | | | |

Marked
Camp
Pine
Yes
Walter F. Gray
Pine
X

Walter F. Gray
Pine
X

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3-RET-1. PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 AND 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 5 AND 6 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 7 AND 8 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 9 AND 10 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 11 AND 12 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 13 AND 14 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 15 AND 16 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 17 AND 18 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 19 AND 20 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 21 AND 22 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 23 AND 24 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 25 AND 26 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 27 AND 28 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 29 AND 30 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 31 AND 32 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 33 AND 34 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 35 AND 36 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 37 AND 38 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 39 AND 40 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 41 AND 42 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 43 AND 44 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 45 AND 46 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 47 AND 48 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 49 AND 50 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 51 AND 52 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 53 AND 54 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 55 AND 56 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 57 AND 58 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 59 AND 60 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 61 AND 62 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 63 AND 64 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 65 AND 66 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 67 AND 68 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 69 AND 70 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 71 AND 72 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 73 AND 74 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 75 AND 76 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 77 AND 78 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 79 AND 80 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 81 AND 82 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 83 AND 84 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 85 AND 86 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 87 AND 88 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 89 AND 90 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 91 AND 92 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 93 AND 94 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 95 AND 96 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 97 AND 98 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 99 AND 100 SHOULD BE USED AS A BURIAL TRANSIT PERMIT.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12089 | |
|--|--|---------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William F. Gray | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> | | MONTH DAY YEAR 5 10 19 82 | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 2 16 47 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 35 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2b. DATE PRONOUNCED DEAD 5 10 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 114 N. Wheeler Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST John A. Gray | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Ruth Adams | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-50-6664 | | 17. INFORMANT Lelia Gray | | | | ADDRESS 114 N. Wheeler Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u>
4413
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER DATE SIGNED 5-11-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Glen Burnie MD | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 14 1982 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |



THE
NATIONAL
RECORD

NO. 1000

THE NATIONAL RECORD

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|----------------------------------|--|-----------------------------------|--|--------------------------------------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | <input type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | |
| (Frank) Franke | | | | | | Green | | 5 | | 5 | | 4 | | 19 | | 82 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| male | black | 6 8 18 | | 63 | | YRS. | | MONTHS | | HOURS | | MIN. | | 5 | | 5 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | <input type="checkbox"/> NEVER MARRIED | | <input type="checkbox"/> WIDOWED | | <input type="checkbox"/> DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | AM | | MD | |
| MD | | USA | | | | | | | | | | Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 201 N. Broadway | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 201 Broadway | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | |
| Thomas | | E. | | Green | | Carrie | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | N/A | | Mary Williamson | | One Ricord St.
Newark, N.J. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Hypertensive cardiovascular disease | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 4009 | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | TITLE (SPECIFY) | | DATE SIGNED | | 5/5/82 | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | Hormez R. Guard, M.D. | | M.D. Assistant | | MEDICAL EXAMINER | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | Hormez R. Guard, M.D. | | ADDRESS | | 111 Penn Street, Balto, MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Burial | | 5/11/82 | | Mt. Auburn Cem. | | Baltimore | | | | MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Wm. C. March F/H | | 1101 E. North Ave. | | MAY 7 1982 | | Francis J. Nathan | | | | | | | | | | | |

DEFENDANT
BOX 10700
LITTLE ROCK, AR 72203

(M)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 0 9 1

| | | | | | | | | | | | |
|--|--|----------------------|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Jerry L. Green | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5 4 1982 | | | 2b. HOUR M | | | | | |
| 1. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 7 10 42 | | 6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS. | | IF UNDER 24 YR. MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR PROVINCE/COUNTRY) NORTH CAROLINA | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5500 Pennington Avenue | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRIVER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | | 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST JERRY GREEN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST BESSIE STONEY | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 212-42-9314 | | |
| 17. INFORMANT JERRY GREEN | | | ADDRESS 2600 E. HOFFMAN ST. | | | 17a. DATE OF OPERATION | | | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8227 IMMEDIATE CAUSE (a) Crush Injury of Head
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Building subject caught between truck and train | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 8:40xx 5 4 1982 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) chemical company | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE 5500 Pennington Ave., Baltimore, Maryland | | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | 22b. DATE 5-8-82 | | | 22c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PK. | | |
| 22d. LOCATION
CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | 22e. DATE REC'D. BY REGISTRAR MAY 10 1982 | | | 22f. REGISTRAR'S SIGNATURE <i>James J. Smith</i> | | | 22g. REGISTRAR'S NAME James J. Smith | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 5-8-82 | | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PK. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME E.L. PHILLIPS | | | ADDRESS 1721 N. MONROE ST. | | | 25a. DATE REC'D. BY REGISTRAR MAY 10 1982 | | | 25b. REGISTRAR'S SIGNATURE <i>James J. Smith</i> | | |
| 25c. REGISTRAR'S NAME James J. Smith | | | ADDRESS 1721 N. MONROE ST. | | | 25d. DATE REC'D. BY REGISTRAR MAY 10 1982 | | | 25e. REGISTRAR'S SIGNATURE <i>James J. Smith</i> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

15051

2008 COLLECTOR: VIBER
KEVIN W BOND



YAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 0 9 2 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 3. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Lessie L Green | | | | 7a. DATE OF DEATH MONTH DAY YEAR HOUR
5 - 13 - 82 11:50 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR
2 25 81 | | 6. AGE (IN YEARS LAST BIRTHDAY)
14 mos YRS MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Cyde | | 15. MOTHER'S MAIDEN NAME
Villette GREEN | | 16. STREET ADDRESS
21 S. CAREY ST. | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 17b. SOCIAL SECURITY NO.
NA | | 17. INFORMANT ADDRESS
PHYLLIS ROUZER 21 S. CAREY ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). CARDIORESPIRATORY Arrest
3201 DUE TO, OR AS A CONSEQUENCE OF
(b). Pneumococcal Meningitis
DUE TO, OR AS A CONSEQUENCE OF
(c).
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mins
3 days | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
Down's Syndrome, Nasal Chondral Necrosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10-1982, to 5-13-1982, that (I) (we) saw the deceased alive on 5-13-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Alvin R. Sills, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alvin R. Sills, MD | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE MD | |
| 24. FUNERAL DIRECTOR NAME
March Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | | | |
| ADDRESS
1101 North Ave | | | | 25b. REGISTRAR'S SIGNATURE
Francis J. [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|---|--|---|---|---|---|--|---|---|---|--|--|
| 8 2 1 2 0 9 3 | | | | | | | | | | | |
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM GREEN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 18 82 | | | | | 2b. HOUR
5:45p M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 8 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
66 | | 7. IF UNDER 24 HRS
HOURS MIN.
5:45p M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(GIVE FULL NAME AND STREET ADDRESS)
VAMC BALTIMORE, MARYLAND 21218 | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1041 N. Fulton Avenue | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willie O. Green | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada S. Jones | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
710 09 5634 | | 17. INFORMANT
Helen S. Green | | 17. ADDRESS
1041 N. Fulton Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS - BACTERIAL.
DUE TO, OR AS A CONSEQUENCE OF (b) GI BLEEDING
DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC ADENOCARCINOMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Day.
5 Days
2 months. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Metastatic Squamous Cell Lung CA, THROMBOCYTOPENIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(GIVE DATE OF MEDICAL EXAMINATION) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 82 | | 21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from April 8 , 19 82 , to May 18 , 19 82 , that (1) (we) lost
saw the deceased alive on MAY 18 , 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated
above, (b) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Stephen Puentes | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/18/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Puentes, M.D. | | | | | | 22e. ADDRESS
VA Hosp. Baltimore. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H, Inc. | | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 20 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | |

1



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MAY 20 1982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 0 9 4

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
LEON L GREENBERG | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 12 1982 | | 2b. HOUR
11:37p |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MAR. 13, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY)
75 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
ENGLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROPRIETOR | 12b. KIND OF BUSINESS OR INDUSTRY
JEWELRY STORE | |
| 13a. COUNTY
MARYLAND | 13b. CITY OR TOWN
BALTIMORE | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
3401 PARKWAY RD. 21215
TEAKWOOD LA. SARASOTA FL 33582 | | |
| 14. FATHER'S NAME
SIMON | MIDDLE
GREENBERG | 15. MOTHER'S MAIDEN NAME
SOPHIA | MIDDLE
UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, IF UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | 16b. SOCIAL SECURITY NO.
215-14-8306 | 17. INFORMANT
MRS. REBECCA GREENBERG 4001
TEAKWOOD LA. SARASOTA, FL 33582 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF
(b) DIFFUSE HISTIOCYTIC LYMPHOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) 2000
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18h
3yrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
HIGH OUTPUT CONGESTIVE HEART FAILURE | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/8/82 19 to 5/12/82 19, that (I) (we) last saw the deceased alive on 5/12/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE
LD SNYDER MD | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LD SNYDER MD | | 22e. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
MAY 14, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
SHAAREI ZION | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | 25a. DATE REC'D. BY REGISTRAR
MAY 17 1982 | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial permit. Please retain your copy of this certificate for 1 year. A copy should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, a medical examiner must be notified.

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UNITED STATES
DEPARTMENT OF THE ARMY
HEADQUARTERS



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

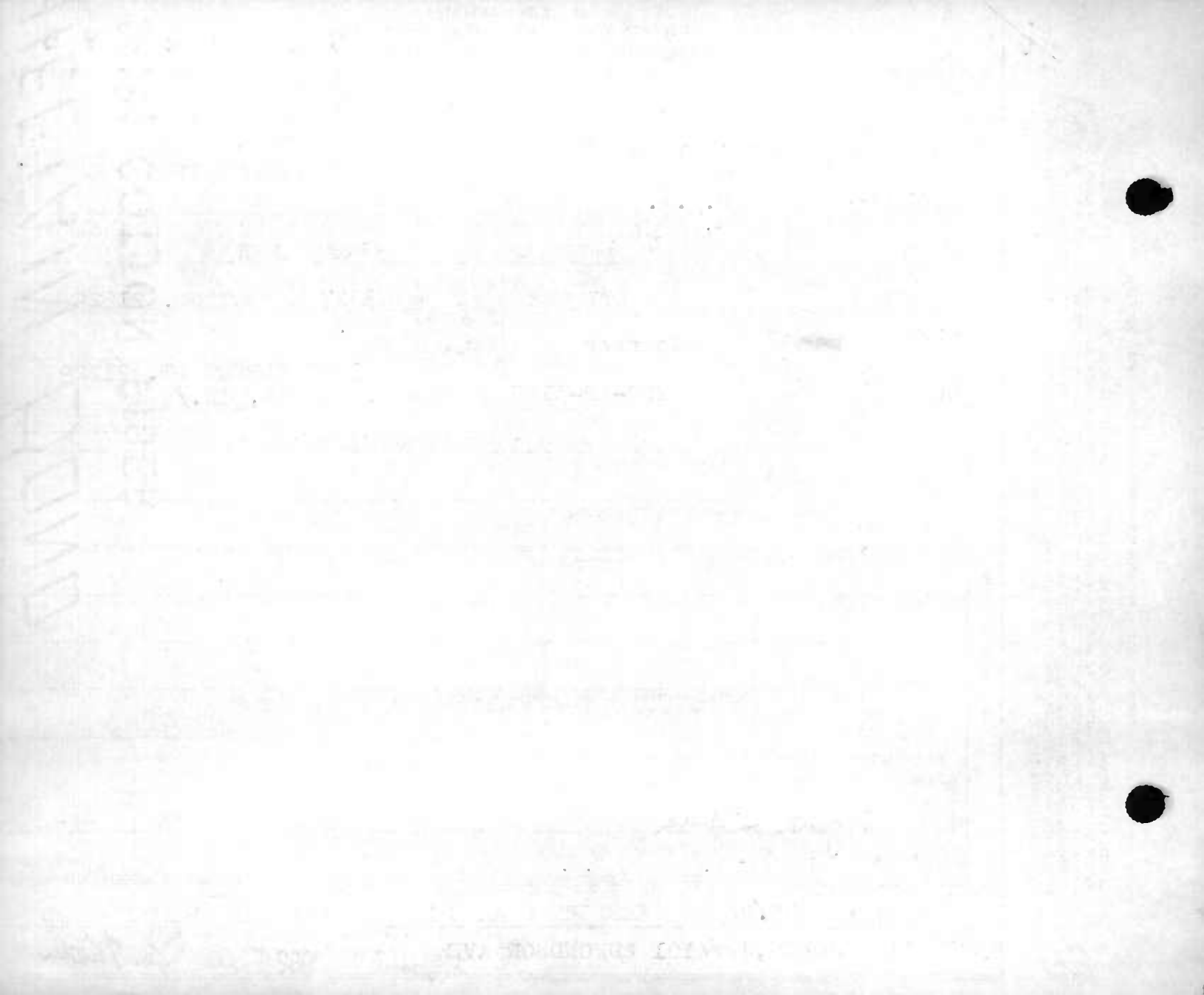
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 0 9 5

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|------------------|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helena A Greene | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
5 3 1982 | | | 2b. HOUR
M
5:30 P.M. | | |
| 3. SEX
Female | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV 30 1920 | 6. AGE (IN YEARS)
LAST BIRTHDAY
61 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
5 3 1982 | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3327 Elbert Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3327 ELBERT ST. 21229 | |
| 14. FATHER'S NAME
Isiah Johnson | | | 15. MOTHER'S MAIDEN NAME
FLORENCE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-12-5125 | | 17. INFORMANT
3327 ELBERT ST. 21229
REUBEN V. GREENE, JR./ | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
4292
(b) _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<u>Virginia L. Dolan</u> | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
5-4-82 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
05/06/82 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTERN STAR CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE BALTO MD | | |
| 24. FUNERAL DIRECTOR
MARSHALL W JONES, JR./4101 EDMONDSON AVE | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 6 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James Van Nuthen</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 9 6 | |
|--|--|--|----------------------|---|---|---|---|--|--|---|--|
| FOR
1- STATE
REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
John T R. Greenwood, Jr. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5/18/82 | | | | | 2b. HOUR
10:15 P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 15 24 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY)
Ind. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Labor | | | 12b. KIND OF BUSINESS OR
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Ind. STATE | | 13b. COUNTY
Ind. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
64 S. Carrollton Ave. 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Greenwood | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Foreman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT
ADDRESS
Blair Louise League - 1607 Marley Ave. 21061 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4254
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Muscular Dystrophy | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN IDENTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
AT HOME <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18/82, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on 5/18/82, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
EH Miller | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
5/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EH MILLER | | | | | 22e. ADDRESS
University Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(RECEIVED)
Burial | | | 23b. DATE
5-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Cemetery, Inc. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Int. Annapolis, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
James J. Cowan, Jr. 901 Indiana St. | | | | | 25. DATE REC'D. BY REGISTRAR
MAY 21 1982 | | | | | | |

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MAILED 16 JAN 1964

RECEIVED
FEB 10 1964
U.S. AIR FORCE
AIR MAIL



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 0 9 7 | |
|---|--|------------------------------|--|--|--------------------------|------------------------------------|---|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| Helen M. Greffen | | | | | 5-12-82 | | | | | 6:17PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | |
| Female | | White | | 11 04 10 | | | 71 YRS | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | John Hopkins Hospital | | | | Canvas Service | | Awning | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| 13a. STATE | | | | | 13b. COUNTY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 438 S. Smallwood St., 21223 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Pete Costanzo | | | | | Mary Board | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | | | 212-12-0871 | | Charles F. Greffen, Jr. 6047 Old Washington Road | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | 5 mins | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION | | | | | | | | | | 5 days | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 5/12/82 | | | | EMBOLUS (R) leg. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | 19 | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the doctor) attended the deceased from May 10, 1982, to May 12, 1982, that (I) (the doctor) saw the deceased alive on May 12, 1982, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (the doctor) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| W. G. McKenna | | | | | | M.D. | | | May 12 1982 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| MCKENNA | | | | | | Johns Hopkins Hospital, Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| Entombment | | | | 05-15-82 | | Loudon Pk. Mausoleum | | | Baltimore City Maryland | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | 21229 MAY 14 1982 | | | Renee Jean Nathan | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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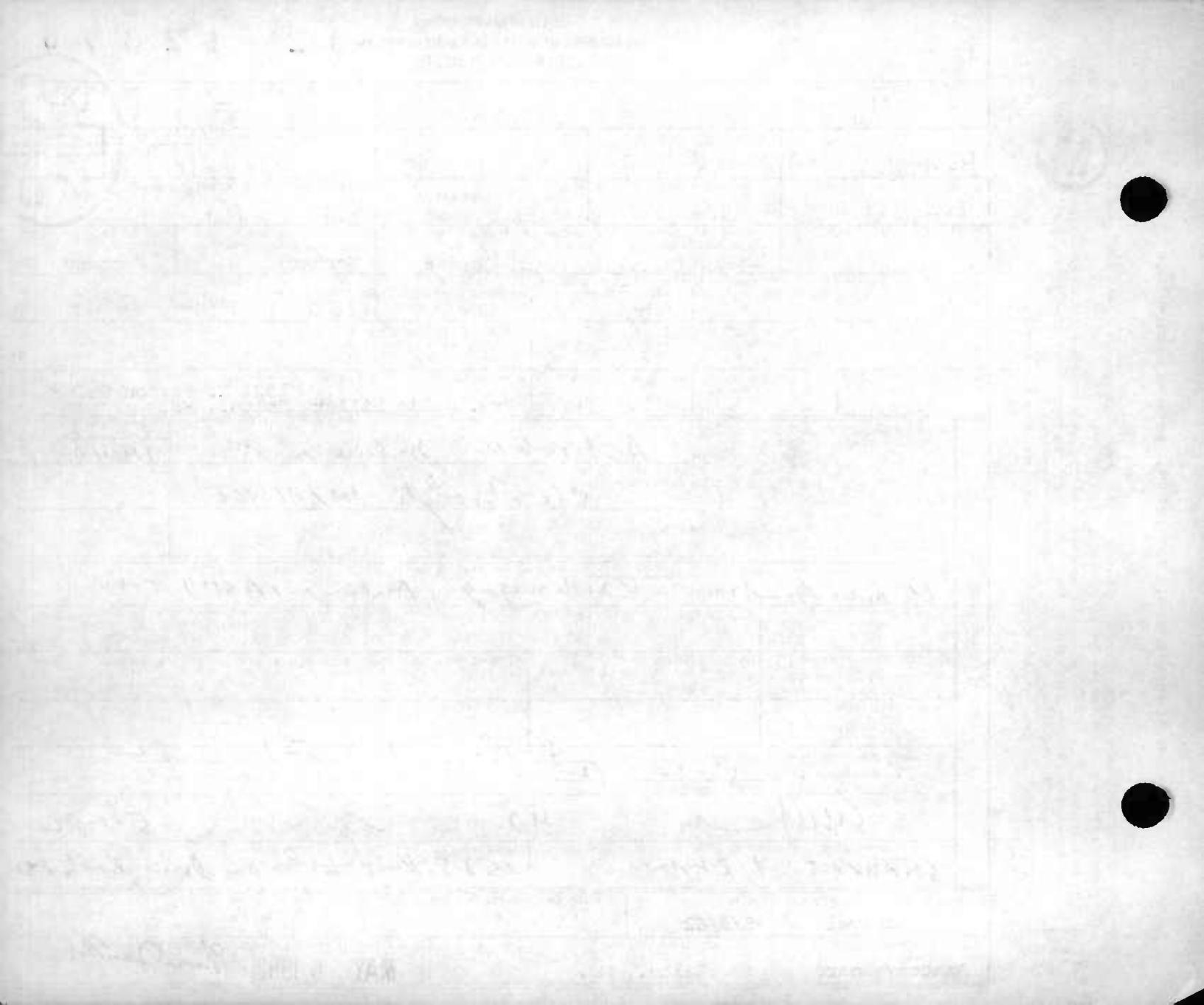
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 2 0 9 8
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary Grier | | | 2a. DATE OF DEATH
MONTH 5 DAY 1 YEAR 82 | | | 2b. HOUR
2:37 PM | | | | |
| 3 SEX
Female | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH 7 DAY 1 YEAR 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lafayette Square Nsg. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Factory | | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore City | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1521 N. Payson Street | | |
| 14. FATHER'S NAME
FIRST John MIDDLE W. LAST Miller | | | 15. MOTHER'S MAIDEN NAME
FIRST Julia MIDDLE Miller LAST Miller | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | |
| 16b. SOCIAL SECURITY NO.
215 09 8927D | | | 17. INFORMANT
Mrs. Julia Miller | | | ADDRESS
1521 N. Payson St. Balto., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonia
2769
DUE TO, OR AS A CONSEQUENCE OF
(b) Electrolyte imbalance
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Ch. Bronchitis, Cardiomegaly, Anemia, ASHD, CHF | | | | | | | | | | |
| 19a. DATE OF OPERATION
5-1-82 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ch. Bronchitis | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-10-1979 to 5-1-1982 , that (I) (we) last saw the deceased alive on 5-1-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Shaukat Y. Khan | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
5-1-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHAUKAT Y. KHAN | | | 22e. ADDRESS
1528 Knig William Drive, Balto, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Removal | | | 23b. DATE
5/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Anatomy Board ADDRESS Balto., Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 6 1982 | | 25b. REGISTRAR'S SIGNATURE
James G. [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| <div style="text-align: right;">8 2 1 2 0 9 9</div> <div style="text-align: center;"> CERTIFICATE OF DEATH
 REG. NO. </div> | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) MARIE R GROSS | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 5/23/82 | | 2b. HOUR
10-18 PM | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR FEB-7-03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
V. A | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PROV. Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2100 Rupp St | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Beller Burell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elenora | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <input type="checkbox"/> | | | | 16b. SOCIAL SECURITY NO.
216-09-5119 | | 17. INFORMANT
ADDRESS
Henrietta Harpers 1520 Pulaski St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrhythmias
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) complete heart block.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) CHF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/23 , 19 82 , to 5/23 , 19 82 , that (I) (we) lost saw the deceased alive on 5/23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
M. A. RASHDAN M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. A. RASHDAN | | | | 22e. ADDRESS
2600 LIBERTY HEIGHT | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
5/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | | |
| 24. FUNERAL DIRECTOR
NAME
VERNON BALNEY | | | | ADDRESS
1348 CALHOUN ST | | 25a. DATE REC'D. BY REGISTRAR
MAY-27-1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Hook | |

3

1503 BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 1 0 0

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Martha C. Grubbs</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>5-1-82</i> | | 2b. HOUR
<i>6:30 a.m.</i> |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>1 99</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>83</i> YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>VA</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTO CITY</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>BALTO</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>BALTO CITY Hosp</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HSWE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>-</i> |
| 13a. STATE
<i>MD</i> | 13b. COUNTY
<i>BALTO</i> | 13c. CITY OR TOWN
<i>DUNDALK</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
<i>17 WOODLAND AVE</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>TATUM</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MARY JANE</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
NAME ADDRESS
<i>BERTHA Hughes 17 Woodland Dundalk</i> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>5 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from <i>3/17</i> 19 <i>82</i> , to <i>5/1</i> 19 <i>82</i> , that (a) (we) lost
saw the deceased alive on <i>5/1</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>L. J. Appl</i> | | DEGREE | | 22c. DATE SIGNED
<i>5/1/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Lawrence J. Appl</i> | | 22e. ADDRESS
<i>Baltimore City Hospital</i> | | | |

| | | | |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | 23b. DATE
<i>May 5-82</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn</i> | 23d. LOCATION
CITY COUNTY STATE
<i>Balto Md.</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Connelly Sons - 300 Mace-Essex</i> | | 25a. DATE RECEIVED BY REGISTRAR
<i>MAY 4 1982</i> | 25b. REGISTRAR'S SIGNATURE
<i>Frances Van Nostrand</i> |

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WASHINGTON, D. C.

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BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 1 0 1 | | | |
|--|--|---|--|---|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| RICHARD J. GUARNERA SR. | | | | 05 16 82 | | | | A M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 09 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
302 S. WOODYEAR ST., 21223 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BARBER | | 12b. KIND OF BUSINESS OR INDUSTRY
SELF-EMPLOYED | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
302 S. WOODYEAR ST., 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SALVADORE --- GUARNERA | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CONSETTA --- DANTONI | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
ALEXANDRIA H. GUARNERA | | ADDRESS
302 S. WOODYEAR ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA OF</u>
DUE TO, OR AS A CONSEQUENCE OF <u>UNKNOWN PRIMARY</u>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 25</u> 19 <u>82</u> to <u>MAY 16</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>MAY 15</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Diana H. Griffiths</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/17/82 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
DIANA H. GRIFFITHS | | | | 22e. ADDRESS
ST. AGNES HOSPITAL, ONCOLOGY DEPARTMENT | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
05-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 1 0 2

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
LEONARD GUERNSEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAY 8, 1982 | | 2b. HOUR
5:00AM |
| 3. SEX
Male | 4. RACE
Cauc | 5. DATE OF BIRTH
MONTH DAY YEAR
July 1, 1902 | 6. AGE
(IN YEARS LAST BIRTHDAY)
79 | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
STATE OR FOREIGN
Indiana | 7b. CITIZEN OF WHAT COUNTRY
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Ch. Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cooper | 12b. INDUSTRY
Furniture | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS OF DEATH)
13b. STATE
Md | | | 13c. COUNTY
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
712 S. Suzanne Ave |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Ramsey | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Abigail | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
215-10-585 | | 17. INFORMANT
Bertha Guernsey | |
| 18. ADDRESS
712 S. Suzanne Ave | | | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROTIC HEART DISEASE | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APR 29</u> , 19 <u>82</u> , to <u>MAY 8</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>MAY 8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
V. Balakrishnan | | | | 22c. DATE SIGNED
MAY 8, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
V. BALAKRISHNAN, MD. | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-11-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Carmel | |
| 23d. LOCATION
(CITY OR TOWN)
Baltimore City, Md | | 24. FUNERAL DIRECTOR
NAME
Raymond J. Kucinski | | | |
| 24a. ADDRESS
255 North | | 24b. DATE REC'D. BY REGISTRAR
MAY 10 1982 | | | |

My dear Mr. [illegible]
 I have just received your letter of the 11th inst. and am
 glad to hear that you are well. I am
 very much interested in the progress of your
 work and hope to hear from you again soon.

Very truly yours,
 [illegible signature]
 [illegible name]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 1 | 0 | 3 |
|---|--|--|--|--|--------------------------|---|--|--|---|--|---|----------------------|-----------------------------------|-----------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | |
| Nina M Gunthrop | | | | | | | | | | May 23 1982 9:10a M | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | | | Black | | | 12 2 20 | | | 61 YRS. | | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| N.C. | | | USA | | | | | | Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | Maryland General Hospital | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 2309 Lauretta Avenue | | | | |
| MD | | | | | | Baltimore | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| John T. Strickland | | | | | Alpha Clark | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | | | N/A | | | | | Madeline Gunthrop 2309 Lauretta Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Adenocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5/82 | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 5/18/82 | | | Malignant Tumor left maxillary sinus | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from May 2, 19 82, to May 23, 19 82, that (we) lost saw the deceased alive on May 23, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) X (not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | 22c. DATE SIGNED | | | |
| X Krishna J. Prasad, M.D. | | | | | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 5/23/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | |
| Krishna J. Prasad, M.D. | | | | | | | | | | c/o Maryland General Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | 5/29/82 | | | Md. Nat'l Mem. Pk | | | Laurel MD | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | 25. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | | | | | MAY 26 1982 | | | [Signature] | | | |

12103

Baltimore City

Maryland General Hospital

Baltimore

Neurotic Rheumatism

Neurotic Rheumatism

Neurotic



12103

Maryland General Hospital

Neurotic Rheumatism

Neurotic Rheumatism

MAY 26 1964

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 3b. HOUR | |
| AMELIA K. HADFIELD | | MAY 11, 1982 | | 07:00AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | White | | 10/11/08 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Balto. | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Balto. | | THE JOHNS HOPKINS HOSPITAL | | Housewife | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | - | | Balto. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | |
| James Kovanda | | Elizabeth (nee Vesely) | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 215-09-6027 | | Kathlees Brown | | Rt5, Box 229D, Mechanicville, Md. 20659 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
<u>4275</u> DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ANOXIC ENCEPHALOPATHY</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CARDIAC ARREST</u>
minutes
days
1/8 month | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> 19 <u>82</u> , to <u>5/11</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>5/11</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>J. A. Hearn</u> MD | | | | 22c. DATE SIGNED
<u>5-11-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JOSEPH A HEARN</u> | | | | 22e. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/14/82 | | Bohemian National | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | | |
| Baltimore, Maryland | | MAY 14 1982 | | | |
| 24. FUNERAL DIRECTOR
Schumaker Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | 25. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 1 0 5
REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM J HAGAN Sr | | | 2a. DATE OF DEATH
MONTH 5 DAY 5 YEAR 82 | | | 2b. HOUR
9⁰⁰ M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 3 DAY 08 YEAR 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE, CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Loader Continental | |
| 12b. KIND OF BUSINESS OR INDUSTRY
oil Co | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
BALTIMORE | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Peter MIDDLE Hagan LAST Hagan | | 15. MOTHER'S MAIDEN NAME
FIRST Marie MIDDLE Buckley LAST Buckley | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
213-18-7622 | | 17. INFORMANT
ADDRESS Mrs Thelma M Hagan
Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) 1350 METASTATIC HEPATOCELLULAR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CARCINOMA
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from MARCH - 28 19 82 , to MAY - 5 19 82 , that (1) (we) lost saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
L. Ceballos MD | | DEGREE
L. CEBALLOS | | | | 22c. DATE SIGNED
5/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. CEBALLOS | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
CITY OR TOWN Baltimore, Maryland STATE | |
| 24. FUNERAL DIRECTOR
NAME Leonard J Ruck Inc. Baltimore, Maryland ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 6 1982 | | 25b. REGISTRAR'S SIGNATURE
Francis J. Nathan | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 21/90 6 | |
|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | |
| Clayton A Haines | | | | 5/6/82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| M | | W | | MONTH DAY YEAR | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 71 YRS. | | U.S. | | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12a. USUAL OCCUPATION | | | |
| Balto. City MD. | | Accountant | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | | St. Agnes Hosp. | | Textile | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | | | Balto. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13d. INSIDE CITY LIMITS? | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Millard C. Haines | | Lillian M. | | 13e. STREET ADDRESS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 214-16-1934 | | Route 1, Box 243-N | |
| No | | | | Mr. Stephen Haines Hedgesville, W. Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) AGRAULOCYTOSIS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) PRONESTYL | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| DIABETES MELLITUS, CHF, DEHYDRATION, ? SEPSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 5.5.19.82 to 5.6.19.82, that (b) (we) lost saw the deceased alive on 5.6.82, 19.82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Geetha Roy MD | | RESIDENT | | 5.6.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Dr. GEETHA RAJA | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| (SPECIFY) | | 5/10/82 | | 23d. LOCATION | |
| Removal | | | | CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | MAY 14 1982 | | Charles Jan Warden | |
| Anatomy Board | | Balto., Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR
1. STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 1 2 1 0 7
REG. NO. | |
|--|--|---|--|---|--|
| I. DECEASED NAME
(TYPE OR PRINT) Marie | | FIRST MIDDLE LAST Hall | | 2a. DATE OF DEATH MONTH DAY YEAR 5/11/82 | |
| 3. SEX F | | 4. RACE B | | 2b. HOUR 4:55 A.M. | |
| 5. DATE OF BIRTH MONTH DAY YEAR 5 8 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt, MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY USA 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lee Andrew Hall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Hardy | | 13e. STREET ADDRESS 663 Portland St. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 216-20-9222 | | 17. INFORMANT ADDRESS Rebecca Miller 663 Portland St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
4310
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) coma, probable intracerebral hemorrhage
(c) hypertension | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 min
3 d |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic renal failure, hemodialysis | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 8 May 19 82 , to 11 May 19 82 , that (I) (we) last saw the deceased alive on 11 May 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death. | | 22b. SIGNATURE W. Myers DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED 5/11/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. MYERS | | 22e. ADDRESS Univ. of Maryland Hosp 22 S. Greene St. | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 5/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn AA CO. Md. | | 24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Pl. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1982 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 2 1 0 8 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| AKA ¹ MARY MARY H. MEREDITH
MARY LOU M. HALL | | | | | 2b. HOUR 05 22 82 11 15 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | MONTH DAY YEAR
08 19 21 | | 60 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| S. CAROLINA | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | 315 S. PARRISH STREET, 21223 | | | | MACHINE OPERATOR | | WINDOW BLINDS | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| MARYLAND | | --- | | BALTIMORE | | 315 S. PARRISH STREET, 21223 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| MAHLON MEREDITH | | | | SARAH LONG | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 247-34-8359 | | LOUISE M. GALBREATH Rt. 1 Box 148 29693 WESTMINSTER, S.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <i>Cocaine</i> | | | | | | | | 2 mo | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bowel obstruction</i> | | | | | | | | 10 mo | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Vaquin Concussion</i> | | | | | | | | 1 YR. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/28</i> 19 <i>81</i> to <i>5/22</i> 19 <i>82</i> , that (I) (we) just saw the deceased alive on <i>5/2</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| <i>William C. Waterfield</i> MD | | | | | | | <i>5/24/82</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| WILLIAM C. WATERFIELD, M.D. | | | | | ST. AGNES HOSPITAL, ONCOLOGY DEPT. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| REMOVAL/BURIAL | | | 05-26-82 | | CONEROSSE BAP. CH. | | WALHALLA OCONN S.C. | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| BALTO., MD. 21229 | | | | | MAY 24 1982 | | <i>James J. [Signature]</i> | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | | | | | |

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 1 0 9
REG. NO. | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) JAMES W. HAMMOND | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 5/27/82 | | 2b. HOUR
4:00 P.M. | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR 6 27 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
400 N. Linwood Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST D. B. Hammond | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Sallie Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS
James Hammond 421 S. Ellwood Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Poisoned Intrabdominal Catastrophe.
4476
DUE TO, OR AS A CONSEQUENCE OF
(b) VASCULITIS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
SEPSIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE
Jeanne G. Cauley M.D.
DEGREE | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/27/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEANNE MCCAULEY M.D. | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
6/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 25a. BY REGISTERED MEDICAL EXAMINER'S SIGNATURE
JUN 1 1982 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
B. Dabrowski & Son 2818 E. Baltimore St. | | | | | | | | | | | |

15109

NOV 23 1947

RECORDED

INDEXED

CHANCERY

NOV 23 1947

11-11-47

Baltimore City

North Carolina U.S.A.

Assembly Room

Good Christian

Baltimore

1400 N. Wood Ave.

Baltimore

U.S.

Baltimore

Selfie

RECORDED

D. B.

723-07-2022 James Howard 401 S. Elmwood Ave.

NOV 23 1947

22

Baltimore

1400 N. Wood Ave.

NOV 23 1947

Baltimore

1400 N. Wood Ave. Baltimore St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 834 BALTIMORE

| FOR
1- STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 1 2 1 1 0
REG. NO. | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DORSIE A HAMPTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 3 82 | | 2b. HOUR
6:45 P.M. |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 15 91 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Head-Bartender | | 12b. KIND OF BUSINESS OR INDUSTRY
Mt. Vernon Club |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2425 Woodbrook Ave.
Baltimore, Maryland 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wade Hampton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Spinnie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-22-0838 | 17. INFORMANT
Berryville, Virginia 22611
Mrs. Florence Paige 218 Josephine St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4860 CARDIO PULMONARY ARREST.
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPTICEMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) PNEUMONIA. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
DEHYDRATION. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-1-1982 to 5-3-1982, that (I) (we) lost
saw the deceased alive on 5-3-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Surjit S. Julka | | DEGREE | | 22c. DATE SIGNED
5/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SURJIT S JULKA | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/8/82 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, County, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
BALTIMORE
HERBERT E. WITTER Funeral Home | | ADDRESS
MAY 5 1982
3035 W. NORTH AVE. | | 25b. REGISTRAR'S SIGNATURE
Anne Jan Norton | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FIRST

MIDDLE

1467

Hamre

M

2d HOUR

MD

Beth Steel

Steel Worker

13e. STREET ADDRESS
159 N. Decker Avenue

MIDDLE LAST
A Lockett

ADDRESS 159 N. Decker Ave.
Balto. MD 21224

| | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
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APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

20 AUTOPSY? YES ☒ NO ☐

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

| 21f. LOCATION | | | |
|---------------|--------------|--------|-------|
| STREET | CITY OR TOWN | COUNTY | STATE |
| | | | |

ACTUAL SIGNATURE Virginia L. Dala M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 5-2-82

ADDRESS 111 Penn Street

| | | | |
|---------------|----------|-------|-------------|
| 23d. LOCATION | COLUMBIA | STATE | MISSISSIPPI |
|---------------|----------|-------|-------------|

| | | | | | |
|-------------------------------|--|----------------------------|--|-------|--|
| CITY/TOWN | | COUNTY | | STATE | |
| y | | Baltimore, Maryland | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |

7922 Wise Avenue, Dundalk, MD 21222

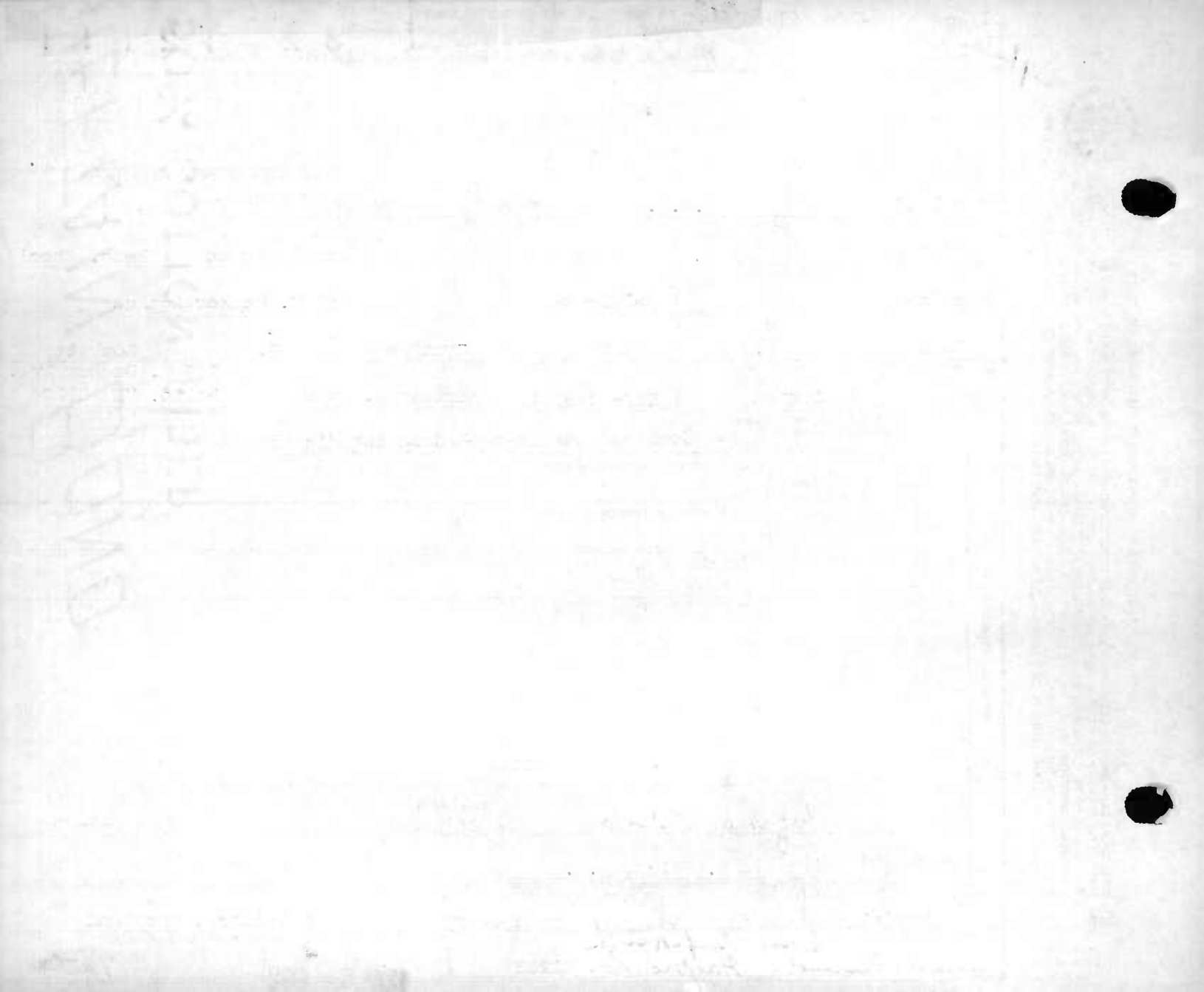
MAY 5 1982 *Blanca San Martin*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. 3. RETAIN PAGE 5 FOR YOUR RECORDS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP _____
DHMH-17
(VR A15 ME (5))
15M 2/80



3

OSL/4 # 055-76-95

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10301 BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 2 | 1 | 1 | 2 | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|------------------------------|---|---|------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MYRTLE BELL HARDY | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 25 82 | | | | | | | 2b. HOUR
11 45 P M | |
| 3. SEX
Female | | | 4. RACE
Black | | | 5. DATE OF BIRTH MONTH DAY YEAR
9 10 11 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 1 HRS
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MD | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
1509 Bank St. | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charlie Dixon | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Jones | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
244-20-4291 | | | 17. INFORMANT ADDRESS
Elenora Lee 3731 White Pine Rd. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4349 IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF, (b) Respiratory Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) probable brain stem infarct | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
3 hours | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/6 , 19 82 , to 5/25 , 19 82 , that (I) (we) last saw the deceased alive on 5/25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Joseph Ahearn MD DEGREE | | | | | | | | | | 22c. DATE SIGNED
5-25-82 | | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH AHEARN MD | | | | | | 22f. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
5/29/82 | | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem. | | | 23d. LOCATION
Baltimore COUNTY | | | 23e. MD | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H | | | | | | 24b. ADDRESS
1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1982 | | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 1 1 3 | |
|--|-------------------------|--|--|--|---------------------------|
| FOR
1. STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) DAVID FIRST M. MIDDLE HARE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAY 7, 1982 | | 2b. HOUR
10:30A |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
5 28 53 | | 6. AGE (IN YEARS LAST BIRTHDAY)
28 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Electronic Tech. | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Upperco | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Sterling R. Hare, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Katherine Graves | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
213-64-2786 | | 17. INFORMANT ADDRESS
Mr. Sterling Hare, Sr., Upperco, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Candida Septis
DUE TO, OR AS A CONSEQUENCE OF (b) multiple bouts of bacterial sepsis
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus
Approximate interval between onset and death: 8 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1 19 82 , to May 7 19 82 , that (I) (we) lost saw the deceased alive on May 7 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Phil Buersch DEGREE MD. | | | | 22c. DATE SIGNED 5/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Phil Buersch | | | | 22e. ADDRESS Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5-10-82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Paul's Cemetery | |
| 23d. LOCATION CITY OR TOWN
Upperco | | 23e. COUNTY
Balto | | 23f. STATE
Md. | |
| 24. FUNERAL DIRECTOR NAME
Eline Funeral Home, Hampstead, Md. | | | | 24b. ADDRESS
21074 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| FOR
1 - STATE
REGISTRAR | | | | | 8 2 1 2 1 1 4
CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR HOUR | | | | |
| John Edward Harkins | | | | | 5 22 82 6:30 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | MONTH DAY YEAR | | 79 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| England | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 700 W. 40th St. - Keswick | | | | Marketing Clerk | | Oil Co. | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | |
| Maryland | | | | | Baltimore | | 7045 Heathfield Rd. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | |
| Thomas Harkins | | | | | Mary Ann Bones | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | ADDRESS | | |
| No | | 233-10-7601 | | Venetta Forney Harkins | | | Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Melanoma with brain metastases</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>16 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>April 22</u> , 19 <u>82</u> , to <u>May 22</u> , 19 <u>82</u> , that (we) lost
saw the deceased alive on <u>May 22</u> , 19 <u>82</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated
above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>W.B. Daniels, Jr.</u> | | | | DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>5/22/82</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>W.B. Daniels, Jr.</u> | | | | 22e. ADDRESS
<u>Keswick, 700 W. 40th St. Balto 21211</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | May 25, 1982 | | Dulaney Valley | | Cockeysville, Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 6500 York Rd. | | MAY 26 1982 | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 8 2 1 2 1 1 5 | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) GEORGE WASHINGTON HARMON SR. | | | | | 2a. DATE OF DEATH
MONTH 5 DAY 4 YEAR 82 | | | | |
| 3. SEX male | | | | | 4. RACE black | | | | |
| 5. DATE OF BIRTH
MONTH 6 DAY 16 YEAR 1926 | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE, MARYLAND 21218 | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Md | | | | | 13b. COUNTY Baltimore | | | | |
| 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS 3145 Ravenwood Avenue | | | | | | | | | |
| 14. FATHER'S NAME
FIRST Will MIDDLE Harmon LAST Harmon | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Lillian MIDDLE Lillian LAST Lillian | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. N/A | | | | |
| 17. INFORMANT Theresa Peacock | | | | | ADDRESS 901 770 Saratoga St Apt | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest
5849
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute Renal Failure
with groin excision
DUE TO, OR AS A CONSEQUENCE OF
(c) Hydradinitis superativa
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 min
4 d
6 wks | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 3/22/82 | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydradinitis superativa | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 28, 1982 to May 4, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 4, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. V. [Signature] DEGREE MD | | | | | 22c. DATE SIGNED 5/5/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. V. [Signature] | | | | | 22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTO. MD 21218 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 5/10/82 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. | | | | | 23d. LOCATION
CITY OR TOWN Crownsville COUNTY MD STATE MD | | | | |
| 24. FUNERAL DIRECTOR
NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1982 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE Frances [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|--|
| 8 2 1 2 1 1 6
CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
WILLIAM J HARMON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5-16-82 | | | | | 2b. HOUR
3:49p.m. |
| 3 SEX
Male. | | 4 RACE
N | | 5. DATE OF BIRTH MONTH DAY YEAR
4-16-86 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76. YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles Hospital. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Det. Guard. | | 12b. KIND OF BUSINESS OR INDUSTRY
Montebello, N.Y. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1653 E. 25th St. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
- | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
- | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-01-6910 | | 17. INFORMANT ADDRESS
Amanda Bosley 3715 Lamoine Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Stomach. with Mets.
1519
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION
Exp. Laboratory 1981 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma Stomach. | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10/1982 , to 5/16/1982 , that (I) (we) last saw the deceased alive on 5/16/1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Kanchhedi | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5-16-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KANCHHEDI L. JAIN. | | | | 22e. ADDRESS
North Charles Hosp. Baltimore | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Rest Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Towson MD | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 19 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas Jan Martin | | | | |

(CHARTER)



11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 1 1 7
REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Russell B. Harper | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 26 82 | | | 2b. HOUR
4:00AM | | | |
| 3. SEX
M | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-12-06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WYMAN PARK HEALTH SYSTEMS | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED NAVY | | 12b. KIND OF BUSINESS OR INDUSTRY
MILITARY | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
7228 Croydon Rd | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN HARPER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAUDE NUNNALLY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
W.W.II 214-26-8198 | | 17. INFORMANT
ADDRESS
Mrs. Rena M. Harper +7228 Croydon Rd | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
5850
DUE TO, OR AS A CONSEQUENCE OF
(b) GI Bleed
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Renal Failure | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
NONE | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
— | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/24/82 , 19 — , to 5/26/82 , 19 — , that (I) (we) last saw the deceased alive on — , 19 — , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE OF
V.A. Berkley R. | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
V. A. BERKLEY. | | | | 22e. ADDRESS
3100 WYMAN PARK DR. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
5-28-82 | | 23c. NAME OF CEMETERY OR CREMATORY
DULANEY VALLEY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
Shirley Miller | | | | ADDRESS
- 7527 Hartford Rd. | | 25a. DATE REC'D. BY REGISTRAR
MAY 27 1982 | | REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |

11-12-11

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11-12-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers 106a and 2 and slide them in 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the body must be examined by a physician.

MEDICAL CERTIFICATION

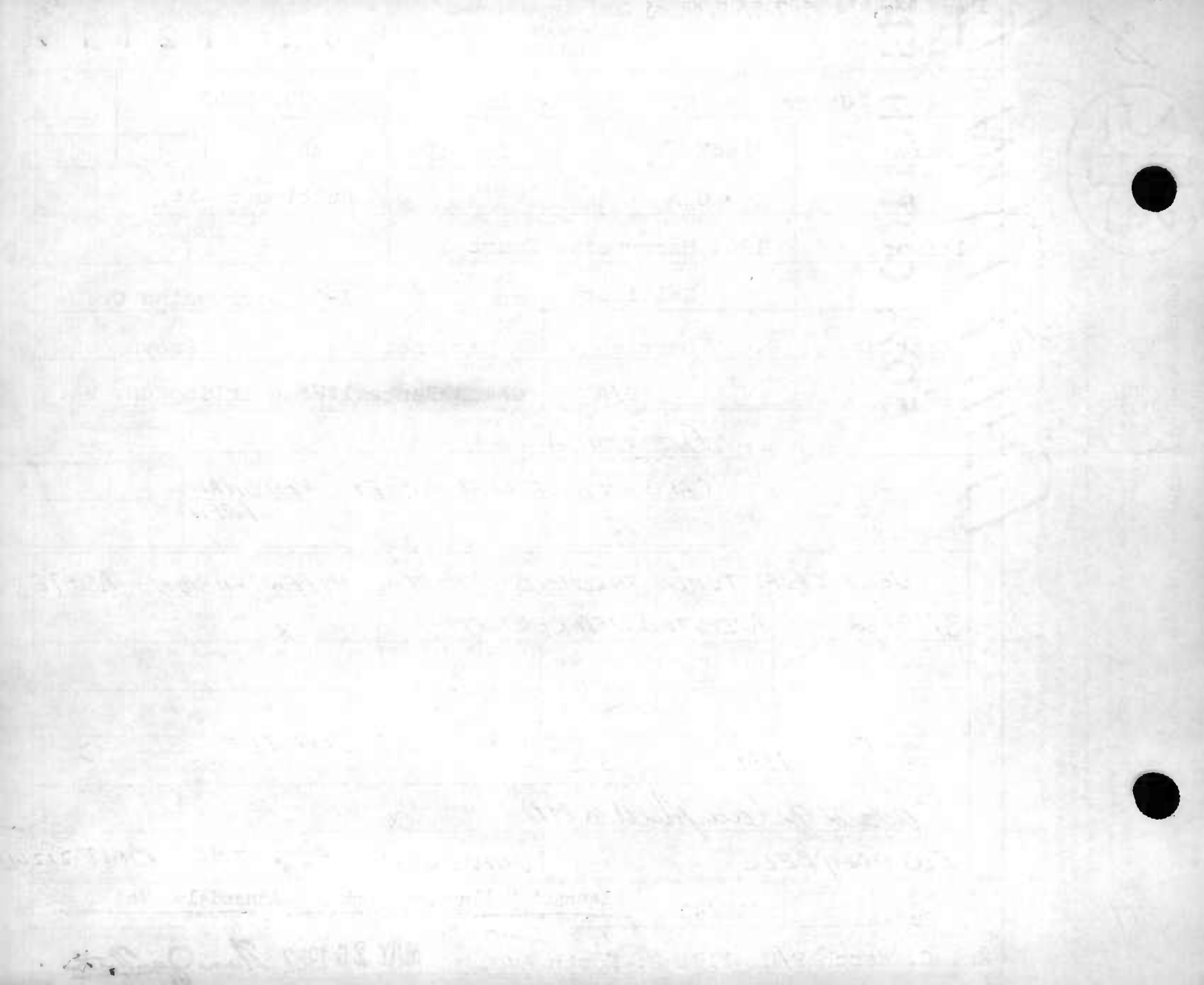
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 2 1 2 1 1 8 | |
|---|--|--|---|--------|---|---|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH |
| CHARLES A. HARRIS | | | | | | MONTH DAY YEAR |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| MALE | | | BLACK | | MONTH DAY YEAR | 45 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| BALTO. MD | | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN HOME FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| BALTIMORE | | | JOHNS HOPKINS HOSPITAL | | DISABLED | |
| 13a. STATE | | | 13b. COUNTY | | 13d. INSIDE CITY LIMITS? | |
| MD | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | 1104 N. Woodyear | |
| WALTER C. HARRIS JR. | | | OLIVIA HARRIS BASKET | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES | | | 212-34-1030 | | OLIVIA BASKET 1104 Woodyear | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | |
| 1469 DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (b) <u>POSSIBLE Respiratory Arrest</u> | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (c) <u>MASSIVE Squamous Cell Cancer of Oropharynx</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| | | | P.M. 19 | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5 May</u> , 19 <u>82</u> , to <u>14 May</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>13 May</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED |
| <u>H. Russell Wright Jr.</u> | | | MD | | | 14 May 1982 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | |
| H. Russell Wright Jr. | | | Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | | 5/15/82 | | Crownsville National | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE RECEIVED BY | | 25b. DATE RECEIVED BY | |
| James A. Morton & Sons F.H. 1701 LAURENS ST. | | | MAY 15 1982 | | MAY 15 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 1 1 9
REG. NO. | |
|--|--|---|--|---|--|---|--|--|---------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James R. Harris | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
May 25, 1982 | | | 2b. HOUR
M | | |
| 3 SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 26 41 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1904 Harryweiss Court | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1904 Harryweiss Ct. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles W. Harris | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Chinn Funeral Home Arlington, VA. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
1890
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARCINOMA OF LEFT KIDNEY - REGIONAL SPREAD
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
VENA CAVAL TUMOR THROMBUS - PORTAL HYPERTENSION - ASCITES | | | | | | | | | | | |
| 19a. DATE OF OPERATION
3/29/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ATTEMPTED NEPHRECTOMY | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from MARCH 4 , 19 82 , to PRESENT , 19 82 , that (1) (we) lost saw the deceased alive on MAY 17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edward N. Campbell M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EW CAMPBELL | | | | 22e. ADDRESS
UNIVERSITY HOSPITAL BALT 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Valley Mem Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Aldie VA | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAY 26 1982 | | | |
| | | | | | | REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 1 2 0 | | | |
|--|--|--|--|--|--|---|--|
| FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Baby Girl Hartley | | | | 5-18-82 | | 6:25P | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | May 11 1982 | | YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Johns Hopkins Hospital | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | --- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| William Graves | | Sylvia Ann Hartley | | | | | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bleeding diathesis (DIC)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Necrotizing enterocolitis</u> | | 19. DATE OF OPERATION | | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Herman Hertz/1907 W Lombard St/Balto Md | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | 1 1/2 hr. | |
| | | | | | | ? | |
| | | | | | | 2d. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</u> | | | | | | | |
| <u>Prematurity</u> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>82</u> , to <u>May 18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>May 18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Pamela J. Stone</u> DEGREE | | | | 22c. DATE SIGNED <u>5/18/82</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| Pamela J. Stone | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 05/20/82 | | Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME | | 24a. ADDRESS | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| Walters Funeral Home/Pratt & Stricker Streets | | Balto Md 21223 | | MAY 21 1982 | | <u>Frances Jean Mathews</u> | |

0 8 1 8 1 1 1

RECEIVED
FEB 11 1972

1

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

NY 100-100000-1000



NY 100-100000-1000
FEB 11 1972
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

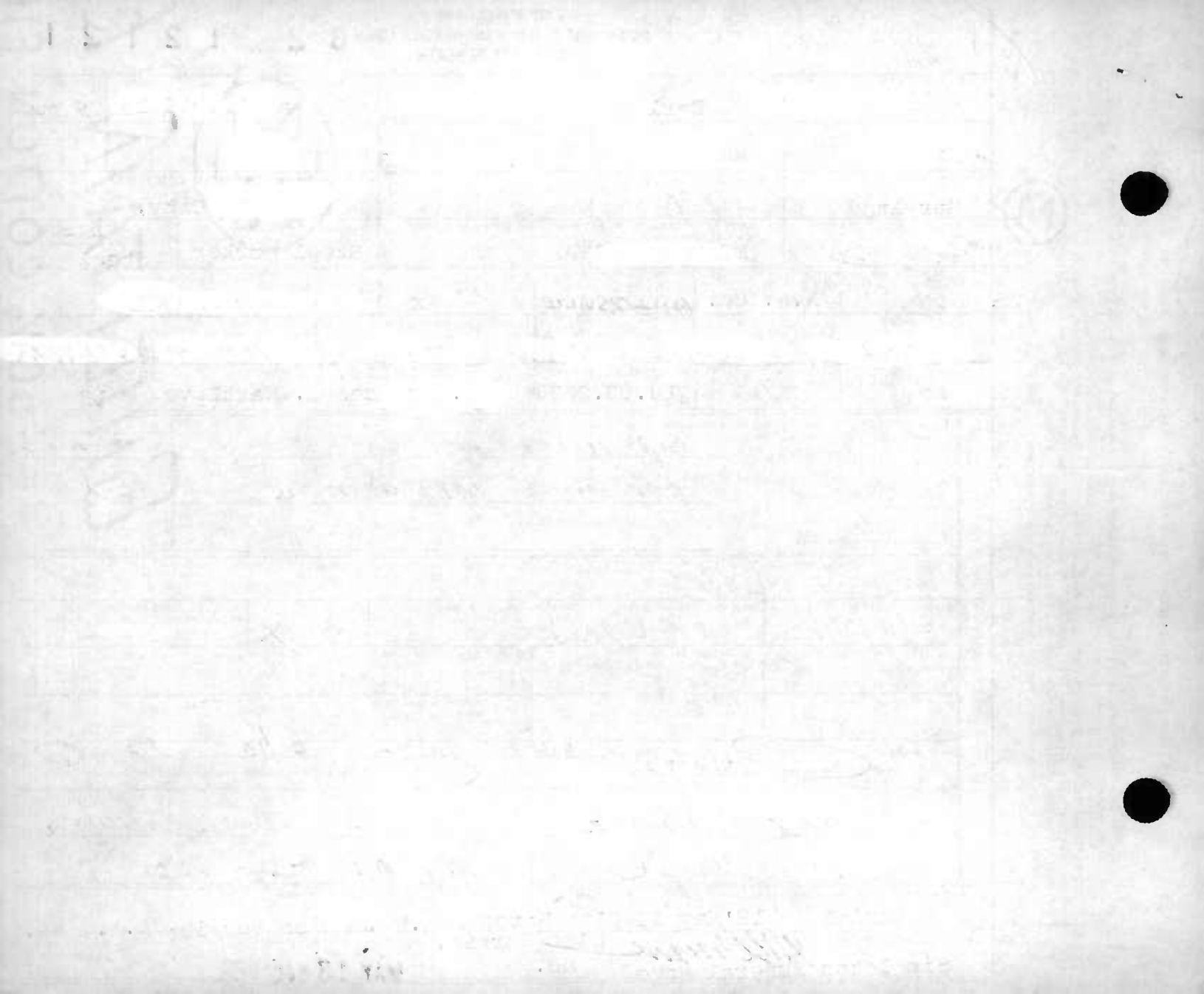
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 1 2 1

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | May 10, 1982 | | | 8:34 AM | | |
| Leslie Earl Hartlove | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| Male | | | White | | | Aug. 10, 1913 | | | 68 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | USA | | | | | | Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALT MD | | | MERCY HOSPITAL | | | Steel Worker | | | Armco Steel | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| BALT MD | | | A.A. Co. MILLERSVILLE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 506 Cairn Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | |
| Thomas Hartlove | | | Sarah Stevenson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT (Wife) | | | ADDRESS | | |
| NO | | | N/A | | | Mrs. Frances I. Hartlove | | | # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | 30 min | | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA OVERLAPPING | | | | | | | | | 6 d | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CA LUNG | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 5/4/82 | | | CALUNG | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/4 19 82, to 5/10 19 82, that (I) (we) last saw the deceased alive on 5/10/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) last did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| Robert C. Moore | | | | | | | | | 5/10/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| Robert C. Moore | | | MERCY HOSP BALT MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 12 May 82 | | | Glen Haven Mem. Pk. | | | Glen Burnie, A.A., MD. | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Singleton Funeral Home | | | MAY 13 1982 | | | Glen Burnie, MD. | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Barry

Leroy

Harvey

2a. DATE KNOWN
OF DEATH ESTI-
MATED

☒ MONTH DAY YEAR
5 18 1982

2b. HOUR
M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Jan. 17, 1958

6. AGE (IN YEARS)

24 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE
PRONOUNCED
DEAD

5 18 1982

2d. HOUR
4:107a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

PM

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
423 E Gittings Street12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Student

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

423 E. Gittings St. Balto. Md.

14. FATHER'S NAME

Audwin

MIDDLE

L.

LAST

Harvey

15. MOTHER'S MAIDEN NAME

Alice

MIDDLE

June

LAST

Troutman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

213-84-8522

17. INFORMANT

ADDRESS

Mr. & Mrs. Audwin L. Harvey, Sameas above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Gunshot wound of head

WEAPON: rifle

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

9552
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
? P.M. 5/18 1982

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

self inflicted wound

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

home

21f. LOCATION

423 E. Gittings Street, Baltimore, Maryland

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒

(Head Only)

Inquiry ☐

and in my opinion

death resulted from:

Natural cause ☐Accident ☐Suicide ☒Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

H. R. Guard

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE
SIGNED

5/19/82

EXAMINER'S NAME
(TYPE OR PRINT)

Hormez R. Guard, M.D.

ADDRESS 111 Penn Street, Balto. MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

May 22, 1982

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION
CITY OR TOWN

Baltimore,

COUNTY

Maryland

STATE

24. FUNERAL DIRECTOR

NAME

McUally Funeral Home, 730 E. Fort Ave. Balto. Md.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

MAY 20 1982

25b. REGISTRAR'S SIGNATURE

Hormez R. Guard

8.2.2.1. 2.1.2.8

CONFIDENTIAL

Handwritten signature or initials.

Printed text at the bottom of the page, possibly a footer or address.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 2 1 2 3 | |
|--|--|---|--|--|--|---|--|--|--|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LOUIS A. HATLE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
5 4 82 | | 2b. HOUR
2 A | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
December 3, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOSPITAL THE UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OR PRINT)
Retired Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET ADDRESS
2807 Kildaire Dr | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Anton Hatle | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Marie ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-05-9813 | | 17. INFORMANT ADDRESS
Mrs Vera Hoshall 7006 Arion Ave | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
4360 DUE TO, OR AS A CONSEQUENCE OF,
(b) Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Massive Left Cerebral Vascular Accident
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
5 days | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/26/ 19 82 , to 5/4 19 82 , that (I) (we) last saw the deceased alive on 5/4/ 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) wash the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Barthel M.D. | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
5/4/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT BARTHEL MD | | | | 22e. ADDRESS
201 EAST UNIVERSITY PARKWAY | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
5/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | | 23d. LOCATION
Baltimore, Maryland STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME
Leonard J Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 5 1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Nuthen | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 1 2 4 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HOWARD A. HAWK | | | | 2a. DATE OF DEATH MONTH DAY YEAR
05 04 82 | | | |
| 3. SEX
MALE | | | | 2b. HOUR
10 ³⁰ A M | | | |
| 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 06 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto city MD. | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
S.S. CHEMICAL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md Balto Balto | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael XXXXX --- Hawk | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hannah XXXXX --- Atkison | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no XXXXX | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-05-2806 | | 17. INFORMANT Betty Parker ADDRESS Fulton, Md. 20759
front sheet 7052 Pindell School Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic obstructive pulmonary disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 4/23 19 82, to 5/3 19 82, that (I (we) last saw the deceased alive on 5/3 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A Barnett MD | | | | DEGREE
MD | | 22c. DATE SIGNED
5-3-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANNA BARNETT | | | | 22e. ADDRESS
3001 S-HANOVER ST. BALTO | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/6/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Homes Balto, Md. 4200 Pennington Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 7 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

PSI 20
DAVIDSON

20 20 20 20



100% COTTON

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 1 2 5 | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST
CLARA HAWKINS | | | | MONTH DAY YEAR
MAY 9, 1982 | |
| 3. SEX
Female | | 4. RACE
Black | | 2b. HOUR
12:13 M | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
1 18 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Roles | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary - | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
N/A | | 13e. STREET ADDRESS
1715 Harford Avenue | |
| 17. INFORMANT
Elizabeth Thornton | | ADDRESS
4809 Kimberleigh Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) 4860
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours
4 days | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5/4/82 19 82 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
5/4/82 82 | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
574 82 | | 22a. I certify that (I) (this hospital) attended the deceased from 5/4/82 19 82 , to 5/9/82 19 82 , that (I) (we) lost saw the deceased alive on 5/4/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Eduardo Marban MD DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED
5/9/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. MARBAN | | 22e. ADDRESS
Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
5/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Zion Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore | | 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H, Inc. | | 25a. DATE REC'D. BY REGISTRAR
MAY 11 1982 | |
| 25b. REGISTRAR'S SIGNATURE
Frances Jan Thornton | | 25c. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

12123

WATKINS CITY

WATKINS CITY

WATKINS CITY

NO. 10



WATKINS CITY

WATKINS CITY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17
(VR A15 ME (1))
15M/2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 12126 | |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John E. Hawkins | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 5 1 1982 | | 2b. HOUR M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH
MONTH DAY YEAR 07 28 53 | | 6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD 5 1 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY HOME IMPROV | |
| 13a. STATE MARYLAND | | | | | | 13b. CITY OR TOWN BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 921 SUE GROVE RD. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST THOMAS HAWKINS | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST ALICE B. BAUBLITZ | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 214589534 | | | | 17. INFORMANT ADDRESS SANDRA HAWKINS 921 SUE GROVE RD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Stab Wounds
9660
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 5 1 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was stabbed | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Bar | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
619 Oldham Street, Baltimore, Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 5-1-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 5/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO BALTO MD. | |
| 24. FUNERAL DIRECTOR'S NAME John Coal | | | | | | ADDRESS 1211 Chesapeake Ave. | | 25a. DATE REC'D. BY REGISTRAR MAY 3 1982 | | 25b. REGISTRAR'S SIGNATURE Frances San Martin | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

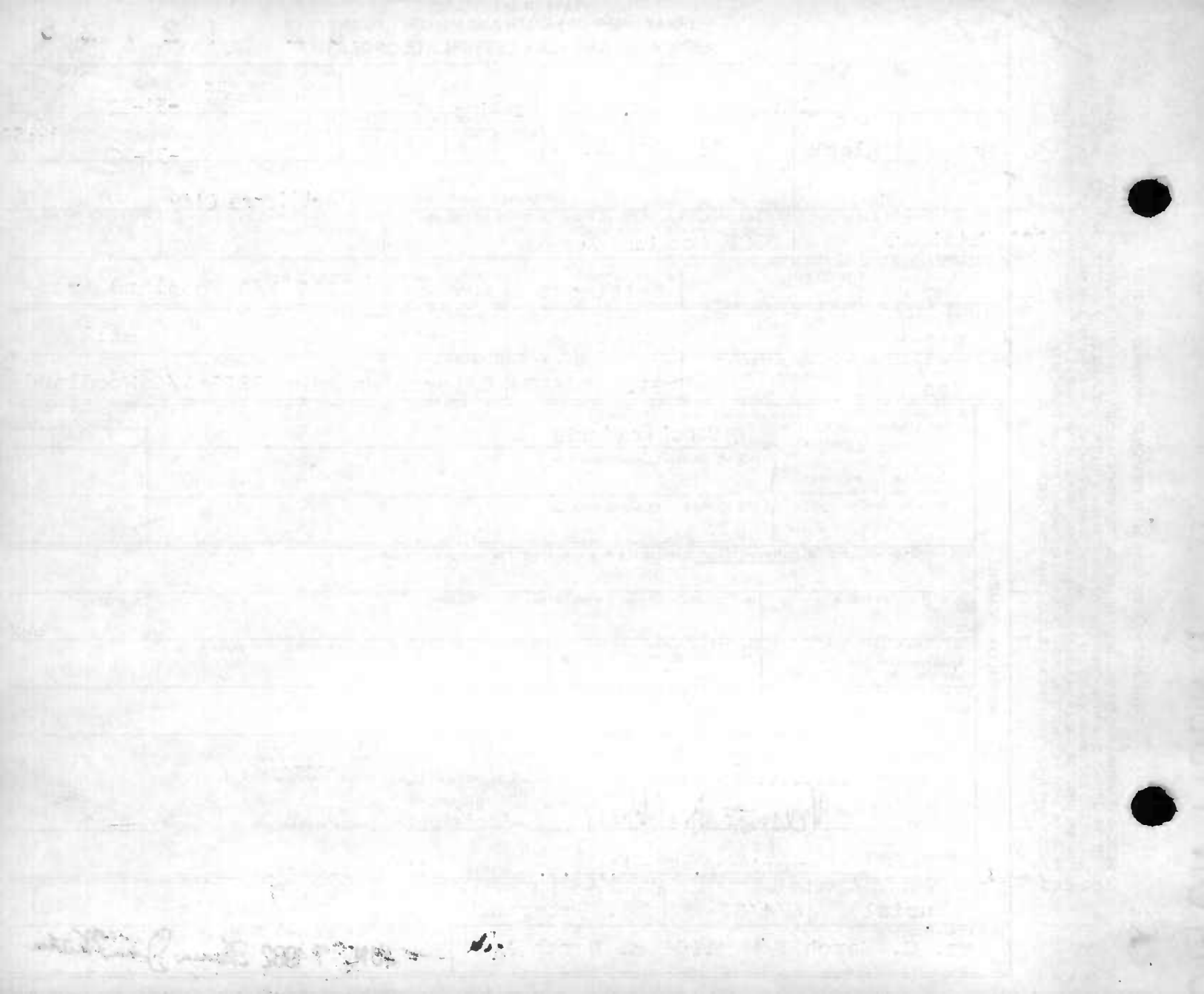
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 2 1 2 7 | | | | |
|---|--|---|--|---|--|--------------------------------------|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | | MONTH DAY YEAR | | | | |
| NORMAN E HAWKINS | | | | | 05/10/82 | | | | | 12:40P | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Male | | Negro | | Aug. 21 1929 | | 52 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Maryland | | USA | | | | BALTIMORE CITY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | THE JOHNS HOPKINS HOSPITAL | | | | | | | | Auto Mechanic | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| 13a. STATE COUNTY | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Box 16 Scaggs Rd. | | |
| 13a. Maryland Calvert | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| William W Hawkins | | | | | Welzetta B. Estep | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| no | | | | | 218-38-7097 | | Viola V. Hawkins Box 16, Scaggs Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypoxia
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) Intra pulmonary Bleeding
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Adeno carcinoma of the Lung
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
1 month
December 1980 | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
status post Right Pneumectomy January 1981, Polio | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/3, 19 82, to 5/10, 19 82, that (I) (we) last saw the deceased alive on 5/10, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Buen Heme | | | | | DEGREE
MD | | | | | 22c. DATE SIGNED
5/10/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. WEINER | | | | | 22e. ADDRESS
Johns Hopkins Hospital Baltimore Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | 23b. DATE
May 14-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Moses Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lothian A.A Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Spencer E. Sewell Box 31, Prince Frederick, Md | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 14 1982 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 2 1 2 8 | | | | | |
|---|--|------------------|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Ralph B. Hawkins Sr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED XX MONTH DAY YEAR
5-31-82 | | 2b. HOUR
M
12:58
A | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 11 24 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
57 YRS. | | 7. DATE PRONOUNCED DEAD
MONTH DAY YEAR
5-31-82 | | 2d. HOUR
M
12:58
A | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3322 1/2 Woodland Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3322 1/2 Woodland Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ralph Hawkins | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie Hill | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
216-18-6874 | | | | 17. INFORMANT
ADDRESS
Delores Hawkins 3322 1/2 Woodland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
1990
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>Margarita A. Korell</u> | | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER
DATE SIGNED 6-2-82 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
6/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | | | | |
| 24. FUNERAL DIRECTOR
Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JUN 7 1982 | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Smith</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 1 2 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BABY GIRL DAVIS HAYES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
5 8 82 | | 2b. HOUR
9.42 PM | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
5 8 82 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
BIRTHDAY YRS MONTHS DAYS HOURS MIN.
3 23 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTI | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNI. OF MD. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTIMORE | 13c. STREET ADDRESS
202 9 W SARATOGA ST | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GARL L HAYES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DESIREE J HAYES | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) NON-VIABLE FETUS
7650
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 hours 23 mins | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 th May 19 82 to 8 th May 19 82, that (I) (we) lost the deceased alive on 8 th May 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
S. Tharmarajah | | | | 22c. DATE SIGNED
5/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. S. THARMARAJAH | | | | 22e. ADDRESS
22 GREENE ST, BALTIMORE MD. | |

| | | | |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | 23b. DATE
5/14/82 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., Md. | 25a. DATE REC'D. BY REGISTRAR
MAY 21 1982 |
| | | 25b. REGISTRAR'S SIGNATURE
Francis J. Nathan | |

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EXHIBIT A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to perform an autopsy.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 2 1 3 0 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST <u>GAIL</u> MIDDLE <u>WILSON</u> LAST <u>HAYTER</u> | | | | MONTH <u>5</u> DAY <u>21</u> YEAR <u>82</u> | | | |
| 3. SEX <u>MALE</u> | | | | 2b. HOUR <u>4:30</u> A.M. | | | |
| 4. RACE <u>WHITE</u> | | | | 5. DATE OF BIRTH | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u> | | | | MONTH <u>August</u> DAY <u>12</u> YEAR <u>1913</u> | | | |
| 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore City</u> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mercy Hospital</u> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | | | |
| 13a. STREET ADDRESS <u>15 DALLAM AVENUE - Apt. 5A</u> | | | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST <u>Zollie</u> MIDDLE <u>Anderson</u> LAST <u>HAYTER</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Bertha</u> MIDDLE <u>ROE</u> LAST <u>Garrett</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | | | 16b. SOCIAL SECURITY NO. <u>226-18-5988</u> | | | |
| 17. INFORMANT (Name) <u>Sam</u> ADDRESS <u>319 Mastland Street BEL Air, Maryland 21014</u> | | | | 17. INFORMANT (Name) <u>Sam</u> ADDRESS <u>319 Mastland Street BEL Air, Maryland 21014</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> | | | | | | | |
| 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>RESP FAILURE</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> 19 <u>82</u> to <u>5/21</u> 19 <u>82</u> that (I) (we) lost the deceased alive on <u>5/21</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE <u>Larry Feldman</u> | | | | 22b. DATE SIGNED <u>5/21/82</u> | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LARRY FELDMAN</u> | | | | 22d. ADDRESS <u>301 ST PAUL ST BELT MD 20212</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | 23b. DATE <u>May 24, 1982</u> | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Belt Memorial Gardens</u> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Belt Md 20212</u> | | | |
| 24. FUNERAL DIRECTOR <u>Joseph William Foster</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 25 1982</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | | 25c. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | |

BP _____

U. S. S. R.